



# Instructions for Completing the Individualized Plan of Care

## For Adult DD, Child DD, and ABI Waivers

Effective: November 2012 (If updated, date noted next to link below.)

**Purpose:** Provide instructions, guidance, & references for Case Managers, Teams, & Families on forms & documents required to meet the Individualized Plan of Care approval process.

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## Chapter 1 – Getting Started

### Individualized Plan of Care Requirements

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These instructions are to be used by Case Managers to develop the Individualized Plan of Care (IPC) with input from the Participant, families, and team. All sections of the Individualized Plan of Care are important and are to be specifically written to reflect the Participant’s needs, goals, medical condition, health and safety needs, and behavioral concerns.

The Individualized Plan of Care is to be submitted 30 calendar days before the intended start date in the Electronic Medicaid Waiver System (EMWS).

If an [Individual Budget Amount \(IBA\) Adjustment Request](#) form is submitted with the IPC, it is to be submitted 40 calendar days before the intended IPC start date. This form and all supporting documentation are uploaded in the EMWS “Document Library”, using the [File Naming Convention](#). If you upload an IBA Adjustment Request form, alert your [Participant Support Specialist](#) (PSS) via phone or email of your additional funding request so they know you uploaded the form and can review it.

IPCs submitted without the guardian’s signature are considered “Incomplete” and are not reviewed until the signature is submitted. In extraordinary situations, you can work with your Participant Support Specialist on an agreeable time period for submitting the necessary signatures. Incomplete IPCs submitted to the Division, even if received on time, will be considered “Late”. If this continues to be an issue with additional IPCs, it will be considered a certification issue and referred to Provider Support for corrective action.

You are encouraged to utilize the [Plan of Care Worksheet for EMWS](#), the [Planning Workbook for Individualized Plans of Care](#), the [IPC User Guide](#) and any other forms and documents located in this guide to assist you in preparing and developing an IPC.

### SUMMARY

- **IPC** due **30 calendar days** before the intended start date in EMWS
- **IBA Adjustment** form due **40 calendar days** before intended IPC start date
- IBA Adjustment form is uploaded in EMWS “Document Library” – notify PSS via email or phone
- Supporting documentation is uploaded in EMWS “Document Library” – notify PSS
- **Follow File Naming Convention** for all uploaded documents
- **Guardian Signature required** or IPC considered “Incomplete” and will not be reviewed
- IPCs received “Late” may be referred to Provider Support for corrective action
- Any changes to IPC, all team members must sign after changes are completed
- **Division has final approval on all IPCs**
- Case Managers are responsible for **ensuring training is provided to Providers** regarding all the services & components of IPC

If all components of the IPC are completed at the end of the team meeting, the team can sign the IPC at this time. However, if the team is making changes to the IPC after the meeting, team members must sign it after the changes are completed. If there are changes to the IPC during the approval process, you are required to notify all team members. The Division has final approval of the IPC.

All Providers must verify annually they have been trained on the IPC and all health and safety protocols to keep the Participant safe.

This verification must be kept in the Provider's records and be available upon request by a PSS for review and the [Participant Specific Training](#) form is a helpful tool to document the training.

You are responsible for ensuring all direct care Providers on the IPC receive training on all the services and components of the IPC and any changes made to the IPC during the year. In some cases, the training may be required by a medical professional or family member. Organizations can provide training to their employees once the designated trainer has been trained by you. At the team meeting, the team will identify and document who is responsible for training team members and staff on the IPC or when changes are made to the IPC. If both self-employed Providers and organizations are on the IPC, then you can help coordinate the training between all parties.

**IMPORTANT**

**As of May 2011**, the service pages, schedules, and objectives are no longer submitted to the Division.

However, schedules and objectives are still a requirement for Provider reimbursement.

Objectives and schedules are developed by the Provider, approved by the team, and required to be submitted to the Case Manager at least annually or more frequently as changes are needed, prior to the submission of the IPC to the Division for approval.

The Case Manager documents the progress being made towards achieving the Participant's objectives every month in the Monthly Review and each quarter in Quarterly Review submitted in EMWS.

The Case Manager must receive monthly documentation from the Provider, including progress on the objectives, by the 10<sup>th</sup> business day of the next calendar month.

Service Providers must maintain schedules that meet the Documentation Standards identified in [Chapter 45](#), Section 27 of Wyoming Medicaid Rules.



More details about **Documentation Standards & Monthly & Quarterly Reviews** available online at [BHD - DD Training](#)

## Medicaid Rules [BACK TO INDEX](#)

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All Home and Community Based Waiver Providers are required to sign a Wyoming Medicaid (formerly Equalitycare) and Provider Agreement before being certified to provide services on a Medicaid Home and Community Based Waiver.

This agreement requires that Providers adhere to all applicable federal, state, and Division rules and regulations.

## HIPAA Compliance Requirements [BACK TO INDEX](#)

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A Medicaid Waiver Provider is responsible for having a comprehensive understanding of the **Health Insurance Portability and Accountability Act (HIPAA)** Privacy Rule requirements and regulations. Providers are required to have processes in place to assure Protected Health Information (PHI) is handled appropriately.

HIPAA provides federal protections for personal health information held by covered entities and gives patients, or Participants, rights with respect to that information.

Under HIPAA, Protected Health Information is defined as *“confidential, personal, identifiable health information about individuals that is created or received by a health plan, provider, or health care clearinghouse and is transmitted or maintained in any form.”*

- A “Health plan” includes Government programs, such as Medicaid, that pay for health care.
- “Providers” include home and community based waiver providers.
- “Identifiable” means a person reading the information could reasonably use it to identify an individual.



More details about **HIPAA, PHI, & Secure E-mail** available at [BHD - DD Training](#)

## Protected Health Information [BACK TO INDEX](#)

There are **18 identifiers considered Protected Health Information (PHI)** when shared verbally and in writing (this includes email):

- |   |  |
|---|--|
| 1. Names  | 10. Phone numbers  |
| 2. Street address, city, county, precinct, zip code           | 11. Fax numbers  |
| 3. Date of birth (except year)                                | 12. Account numbers  |
| 4. Social security number                                     | 13. Certificate license numbers  |
| 5. Admission and discharge dates                              | 14. Vehicle identifiers and serial numbers (including license plate numbers) |
| 6. Health plan beneficiary number (including Medicaid number) | 15. Device identifiers and serial numbers                                    |
| 7. Date of death  | 16. Web URLs   |
| 8. Email addresses  | 17. IP (Internet Protocol) address numbers                                   |
| 9. Medical record numbers                                     | 18. Biometric identifiers including finger and voice prints                  |

## Secure Email Requirements [BACK TO INDEX](#)

The Wyoming Department of Health (WDH) provides a secure email system for conducting business on behalf of waiver Participants that will maintain their privacy and comply with HIPAA regulations. Behavioral Health Division (BHD) staff is required to use this secure email system when sending Protected Health Information (PHI) to Providers.

If a Provider receives a secure email from a BHD staff, they must reply using the WDH web-based secure email system. To send a secure email, please contact a BHD staff and request they send you a secure email link. You can use the link to submit your confidential message or attachments containing PHI. If a Provider is unable to use the secure email system, faxes are accepted.

For specific cases with multiple or complex concerns, it is best to make direct contact with the BHD staff for a private discussion.

**Note:** *In order to avoid HIPAA violations, BHD staff is not allowed to share Protected Health Information on their cell phones; therefore, if you have PHI to discuss with BHD staff, please contact them at their office number not their work or personal cell number.*

### VERY IMPORTANT

When sending a secure response to an email that was received from the Division in a secure format, you are required to use the link to the secure web portal within the original email.

Do not simply “reply” via using your default browser.

**Replying to a secure message in your own email browser will not send the message securely.**

## Electronic Medicaid Waiver System (EMWS) [BACK TO INDEX](#)

The Electronic Medicaid Waiver System (EMWS) is a user-friendly web-based application program that allows Case Managers to better manage the Individualized Plan of Care process for a Medicaid waiver administered by the Developmental Disabilities Section.

There are tasks in the electronic waiver process. Each task is assigned to a specific User. The specific Users in the EWMS with definitive roles are the following:

1. **Case Manager (CM)**
2. **Participant Support Program Manager** – Developmental Disabilities Section
3. **Participant Support Specialist (PSS)** – Developmental Disabilities Section
4. **Provider Support Specialist** – Developmental Disabilities Section
5. **Medicaid Eligibility Staff** – Department of Family Services (DFS)
6. **Medicaid Eligibility Supervisor** – Department of Family Services (DFS)
7. **Wyoming Institute for Disabilities (WIND)** – University of Wyoming

After a task is completed by one of the above assigned Users, the system automatically sends the case to the next User in the working queue with an assigned role. This role-based processing is referred to as workflow. **Users are notified via email when they have a task pending completion.**

For additional details and information, refer to the [EMWS Online Resources](#) and [IPC User Guide](#).

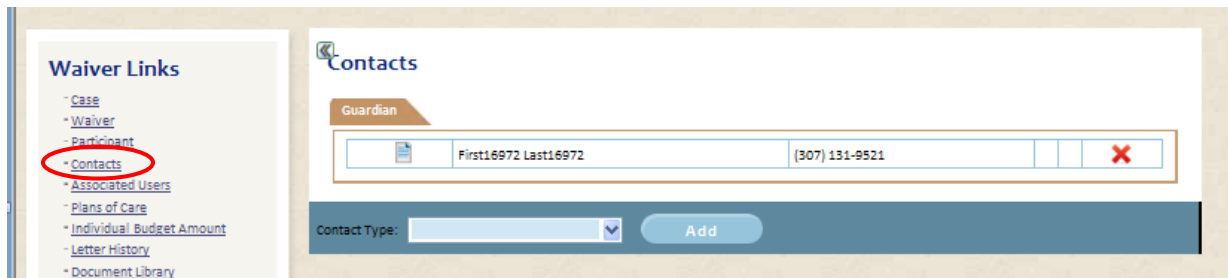
**IMPORTANT**

The system is now electronic; therefore, **the Division no longer accepts mailed or faxed documents** (with the exception of the Case Management Selection Form).

If documents are mailed or faxed, **they will be shredded** and the Case Manager will have to upload them using the [File Naming Convention](#) in the EMWS.

If [File Naming Convention](#) is incorrect, the Division **may send the IPC back**, which may result in the IPC starting late.

## Contacts in EMWS [BACK TO INDEX](#)



The screenshot shows the EMWS interface. On the left, under 'Waiver Links', the 'Contacts' link is highlighted with a red circle. The main content area is titled 'Contacts' and features a 'Guardian' tab. Below the tab is a form with a photo icon, a text field containing 'First16972 Last16972', a phone field containing '(307) 131-9521', and a red 'X' icon. At the bottom of the form is a 'Contact Type:' dropdown menu and an 'Add' button.

- Before starting to work on your IPC, it is recommended you **update all contact information** in “Contacts” under Waiver Links **and keep this information current.**
- Add Payee contact information if applicable in “Contacts”.
- Anytime changes occur, remember to go into the EMWS and update the contact information.
- You are **required to keep this information updated within 7 days after a change occurs.**
- **Upload guardianship papers** (if not already uploaded) in “Contacts” under Waiver Links.
  - Upload guardianship papers anytime there is a change in guardianship or guardianship status, not just at the renewal of the IPC. **The guardianship information must be current.**
- **Delete old information** when changes are made.

**Disclaimer:** Most screen shots used in this guide are fabricated – made-up data solely for the purpose of illustration.

Users, Case Manager or Participant Support Specialist, may be real but the data pertaining to the case is not factual.

## Document Library in EMWS [BACK TO INDEX](#)

**Waiver Links**

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plan Enrollments](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

**Document Library**

Type: Case Manager Selection

D/L	Edit	Type	Filename	Created By	Creation Date	Delete
		Case Manager Selection	ADD.Young.Betty.CMSel.2011.04.22.pdf	rlatham	11/30/2011 12:39:09 PM	

**Upload New Document**

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- Upload the following documents using the [File Naming Convention](#) in “Document Library” under Waiver Links and **be sure to notify your PSS via email or phone that you have uploaded a document**; otherwise, they will not know to look for it here:
  1. **IBA Adjustment form**
  2. **Case Management Selection form**
  3. Additional documentation may include:
    - ✓ **Medical documentation that verifies “related condition”**
    - ✓ Documentation supporting a **request for an environmental modification**
    - ✓ **Order for the use of a restraint** by a physician or designated, trained, and competent qualified behavioral health practitioner with prescription authority is required to be uploaded annually in the Document Library.
    - ✓ **Written verification from the Provider acknowledging a change in units.** This can be a written note, an email, or fax that is scanned from the Provider affected by the change.
    - ✓ **Transition Checklist** – residential move, changing Providers, or changes in Case Manager
    - ✓ **Notification that a Verification form signature is missing** – document why and the timeline for when it will be signed and submitted.
    - ✓ Quotes, invoices, etc. to **prior authorize the purchase of the Goods or Service**
    - ✓ If a **Subsequent Assessment** is not a psychological assessment, upload other assessment

**NOTE:** The Division no longer accepts mailed or faxed documents (with the exception of the Case Management Selection Form). If documents are mailed or faxed, they will be shredded and you will have to upload them using the [File Naming Convention](#) in the EMWS. If [File Naming Convention](#) is incorrect, the Division may send the IPC back, which may result in the IPC starting late.

## Assessment History in EMWS [BACK TO INDEX](#)

**Waiver Links**

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plan Enrollments](#)
- [Letter History](#)
- [Document Library](#)
- **[Assessment History](#)**
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

**Assessment History**

**LT 104**

View	Status	Evaluation Date	Cancel Process
	In Process	8/16/2011	

**ICAP**

There are no ICAP assessments for this waiver case.

**Psych**

There are no Psych assessments for this waiver case.

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- “**Assessment History**” link under Waiver Links is where assessments are uploaded using the [File Naming Convention](#) for each of the following:
  1. 3 pages ICAP summary (upload only if ICAP data is not already in the EMWS)
  2. Psych or Neuropsych evaluation from licensed psychologist or neurologist

## Notes in EMWS [BACK TO INDEX](#)

The screenshot displays the EMWS (Electronic Management and Waiver System) interface. On the left is a sidebar titled 'Waiver Links' containing a list of navigation options: Case, Waiver, Participant, Contacts, Associated Users, Plan Enrollments, Letter History, Document Library, Assessment History, Processes, Targeted Case Management, and Notes. The 'Notes' link is circled in red. The main content area is titled 'Assessment History' and shows a table for 'LT 104' with columns: View, Status, Evaluation Date, and Cancel Process. The table contains one row with a document icon, 'In Process', '8/16/2011', and a cancel process button. Below the table are sections for 'ICAP' and 'Psych', both stating 'There are no ICAP assessments for this waiver case.' and 'There are no Psych assessments for this waiver case.' respectively. The footer contains copyright information for 2011 Wyoming Department of Health and contact numbers for application support.

- When you add comments in the “Notes” link under Waiver Links, **be sure to notify your Participant Support Specialist (PSS) via email or phone that you have added a note**; otherwise, they will not know to review it.
- These are **examples of times to add a “Note”**:
  - After you upload an **IBA Adjustment request** and any supporting documentation -include a description of the request in the “Notes” link.
  - If a request is for a required Subsequent Assessment, Support Brokerage services, or Agency with Choice services, a request form is not required; however, **provide a description why you are asking for these services** in the “Notes” link.
  - Division has 7 days to process a modification from the date that a complete and accurate packet is received. **The PSS has the ability to change the modification date if the submitted information is incomplete. If an exception is necessary**, submit your request in the “Notes” link under Waiver Links.

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## Chapter 2 – Completing the Individualized Plan of Care

### Overview [BACK TO INDEX](#) [TASK LIST USER GUIDE](#)

Effective January 1, 2012, all DD waivers Individualized Plans of Care (IPC) are now completed using the Electronic Medicaid Waiver System (EMWS). Paper IPCs are no longer required; the new system is electronic and has been automated to improve efficiencies.

**When a Participant's IPC is due, you will receive email notification 90-days prior to the due date.** After you log in on your task list, you will see next to the Participant's name under Status, **Submit Plan of Care** indicating your pending task.

**Task List**

Show Filter Contacts

Open processes for all cases that do not require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Last 12074	First 12074	XXX-XX-2074	XX-XXXX2074	DDD - Child	Plan Of Care	Submit Plan Of Care	No	1
	Smith	Ed	XXX-XX-2345		DDD - ABI	Plan Of Care	Submit Plan Of Care	No	1
	Last 12074	First 12074	XXX-XX-2074	XX-XXXX2074	DDD - Child	Renewal	Pending Plan of Care Approval	No	1
	Smith	Ed	XXX-XX-2345		DDD - ABI	Activation	Confirm Financial Eligibility	No	1
	McNichols	George	XXX-XX-9543		DDD - Child	Activation	Confirm Financial Eligibility	No	0
	Richardson	Jason	XXX-XX-8523		DDD - Child	Eligibility	Submit Psych Evaluation	No	0
	McNichols	George	XXX-XX-9543		DDD - Child	Plan Of Care	Submit Plan Of Care	No	0

1 2 3

#### Plan Mod Links

- [Plan Status](#)
- [Individual Preferences](#)
- [Demographics](#)
- [Assessments](#)
- [Circle of Supports](#)
- [Needs, Risks, & Restrictions](#)
- [Medical](#)
- [Specialized Equipment](#)
- [Behavioral Supports](#)
- [Service Authorization](#)
- [Verification](#)

**To complete an IPC, you are required to work through each of the 10 steps under the Plan Mod Links:**

1. Individual Preferences
2. Demographics
3. Assessments
4. Circle of Supports
5. Needs, Risks, & Restrictions
6. Medical
7. Specialized Equipment
8. Behavioral Supports
9. Service Authorization
10. Verification

## Plan Status [BACK TO INDEX](#) [PLAN STATUS USER GUIDE](#)

### PURPOSE:

1. Where you find a link to the Planning Workbook to help you complete your IPCs
2. Shows you the IPC status as it moves through the [process](#) under the “History” tab
3. Where you find PSS comments if your IPC needs corrections or clarifications submitted
4. Where you find notifications in **red print** if something is missing that must be included
5. Where you submit your final IPC to your PSS for review

**Plan Enrollment Dates:** 4/1/2009 - 3/31/2010 (Inactive) **IBA:** \$80,065.00

**Effective Date:** 4/1/2009 (Renewal) **Status:** Complete

**Print:**

**Plan Mod Details**

Plan Enrollment Start Date: 4/1/2009 Plan Enrollment End Date: 3/31/2010

The start date can no longer be changed for this plan, or you do not have permission to change the start date.

**History**

Process: Plan Of Care

Status	Description	Modified By	Modified Date
	Complete		

**Action**

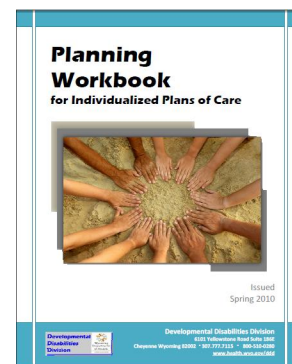
Rollback **Submit**

**Links**

[Planning Workbook for Individualized Plans of Care](#)

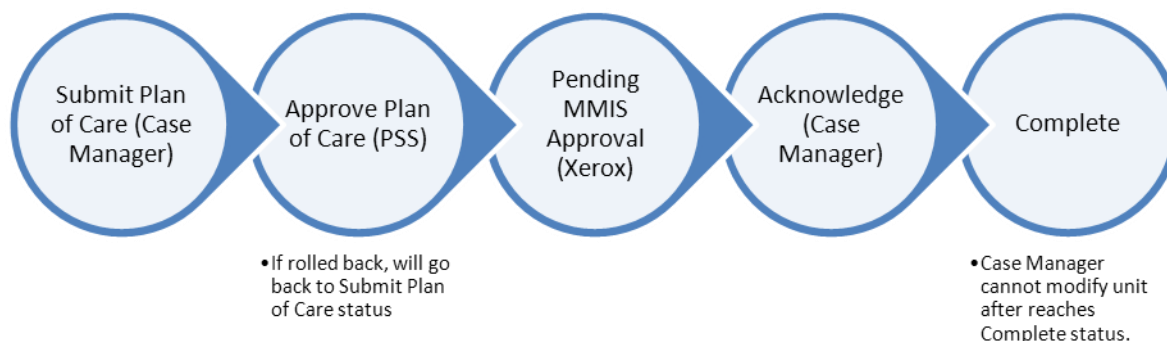
### INSTRUCTIONS:

- After you complete all the steps required to submit an IPC, you return to the “Plan Status” screen to click the “Submit” button under the Action tab to move the IPC through to your Participant Support Specialists (PSS) for review and approval.
- NOTE: There is a link at the bottom of the “Plan Status” screen to access the [Planning Workbook for Individualized Plans of Care](#) for your convenience.

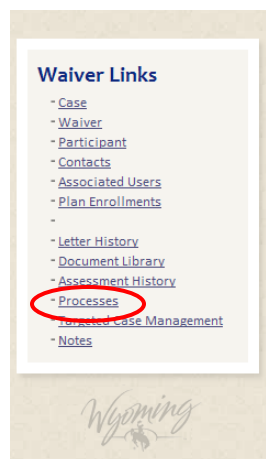


- The “Plan Status” screen will show the status of the IPC as it proceeds through the approval process. The workflow diagram below illustrates the steps the IPC moves through to completion. This is the same workflow process for a modification.

### IPC Approval Process



- If the IPC is reviewed but rolled back to you for corrections or clarifications, **you can access the “PSS Review Summary for All Sections”** tab that will appear on this screen to review the PSS comments advising what needs fixed or clarified. Read through the comments and make the necessary corrections or clarifications requested by your PSS then come back to the “Plan Status” link and click “Submit” to move it through to your PSS for review.



A second way to monitor the IPC status as it moves through the process is through the **“Processes”** link under Waiver Links. This screen enables you to monitor the IPC progress from plan submission, plan approval, pending MMIS, completion, and acknowledgement.

**This page can be printed and furnished to Providers** in lieu of a signed pre-approval page to verify when the Participant Support Specialist (PSS) approved the IPC.

**IMPORTANT**

**You must verify that the IPC has actually been submitted.**

**If you see “Submit Plan of Care” on your task list – it has not been submitted.**

This means that not everything was completed that is required.

There will be errors noted in **red print** on the “Plan Status” link indicating what you must fix.

Or PSS comments will be **under the “Plan Status” link in the “PSS Review Summary for All Sections” tab** explaining what requires clarification, correction, or modification.

You can verify the IPC was submitted under the “Processes” link as it will indicate the PSS has been assigned to Approve Plan of Care.

When the PSS approves your IPC, the status under “Processes” link will indicate Pending MMIS Approval.

Once you complete the pending actions requested by your PSS, “Submit” the IPC again for PSS review.

Refer to the EMWS [FAQ's](#) for more helpful tips as well.

## Individual Preferences [BACK TO INDEX](#) [INDIVIDUAL PREFERENCES USER GUIDE](#)

### PURPOSE:

1. Helpful tools to complete IPC: “About Me” worksheet and Planning Workbook for IPCs
2. Complete the dates for 6 month review, annual team meeting, and modification request
3. Complete a comprehensive person-centered plan for the upcoming year
4. Services, objectives, and schedules identified here must tie in with Service Authorization
5. Activities and preferences identified here must match the schedules

Department of Health

Task List Search Cases Waitlist Reports Admin

Waiver: DDD - Child Participant: McNichols, George Case Manager: Aiken, Kirsten

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- **Individual**
- Demographics
- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

**Individual**

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care

Enrollment: 11/9/2011 - 11/8/2012 (Future)

Plan Start Date: 11/9/2011 Plan End Date: 11/8/2012

Annual Team Planning Meeting: 9/9/2011 6 Month Review (MM/YYYY): 02/2012

Participant's Desired Accomplishments for the Upcoming Plan Year:

enter information here....

Participant's Personal Preferences:

enter information here....

Important Things To Know About Participant:

enter information here....

Save

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### INSTRUCTIONS:

- You must complete the dates for the 6 Month Review and Annual Team Planning Meeting.
- Teams may want to utilize the [Planning Workbook for Individualized Plans of Care](#) or the “[About Me](#)” worksheet to complete this section.
- Remember – **preferences identified here must match the schedules.**
- Be sure to **answer fully the questions for each section.** Write a narrative detailing your answers as more than one sentence is expected. Also remember to use complete sentences and follow the guidelines listed below.

## GUIDELINES

### Person-Centered Planning Approach

- Use a person-centered planning approach to assist the Participant in receiving the supports and services he/she needs to accomplish his/her personal goals.
- Responses must portray a comprehensive picture of the Participant so the team and staff working with him/her will understand how to deliver services and supports around his/her individualized needs and preferences.

### Use Appropriate Language for Responses

- Responses must be written in first person or use direct quotes whenever possible.
- If the Participant is non-verbal, use wording like:  
“My mom says I...” or “Jane Doe, my guardian, says...”
- If the team has additions to the statements, add information stating:  
“The team believes Jane ...”

### Review Questions at Team Meeting

- The questions asked in Individual Preferences can be discussed and answered at your monthly Case Manager home visits or with help from staff. They also must be reviewed at your team meeting. Use this [checklist](#) for guidance.
- This section also will be seen on the “Service Authorization” link so services, objectives, and schedules must support this section.

### Desired Accomplishments

- What are the desired accomplishments this Participant has for the upcoming

year?

### Example of a question Participant can answer:

- a. “What would I like to be able to do this year, which I have not been able to do previously?”
- Summarize progress on habilitation objectives in the past year.
  - Summarize informal goals that “I’ve accomplished this past year”. Give an overview of important events in the Participant’s past year that are relevant to the Participant’s goals and planning.

### Preferred Activities

- Activities identified in this section are reflected in the services the Participant is receiving through the schedules of those services.

### Examples of questions Participant can answer:

- a. “Whom do I like to spend time with?”
- b. “What things do I do in the Community?”
- c. “What help do I need to go where I want to go?”

### Important Things to Know

- See the [Planning Workbook for Individualized Plans of Care](#) or the “[About Me](#)” worksheet as an aid in answering the following “I” information:
  - a. What causes me to feel sad, hurt, angry, or scared?
  - b. What can Providers do to help me when I feel these things?
  - c. What is my health and safety plan?

## Demographics [BACK TO INDEX](#) [DEMOGRAPHICS USER GUIDE](#)

### PURPOSE:

1. Provide updated demographics and current contacts information for the Participant  
(Use “Contacts” link to upload Guardian & Power of Attorney papers)
2. Required to keep this information updated within 7 days after a change occurs

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual
- **Demographics**
- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care

Enrollment: 11/9/2011 - 11/8/2012 (Future)

**Participant**

**Demographics**

Last Name: Last21520 First Name: First21520

Middle Name: Suffix:

SSN: 111121520 Medicaid ID: 00-00021520

Birth Date: 9/9/1951 Gender: Male

Ethnicity: White, Not Hispanic Method of Contact:

Communication Barriers:

County: Laramie

**Addresses**

Type	Street Address	City	State	Zip Code
Physical	111 Center St Apt 2B	Cheyenne	Wyoming	82009

Add

**Phone Numbers**

Type	Phone Number	Primary
Home	(307) 667-5762	Yes

Add

**Email Addresses**

Type	Email Address	Primary
Personal	bmcnichol112@yahoo.com	Yes

Add

Save

### INSTRUCTIONS:

- Accurate and current information is essential.
- Use the **Participant’s legal name**. Put preferred name in parentheses.
- Indicate **Gender, Ethnicity, Preferred Method of Contact, and County**.

- Document any **Communication Barriers** such as the need for an interpreter, hard of hearing, uses a language device, primary language if other than English, non-verbal, or any other significant barriers to communication.
- Enter complete addresses including: Street, P.O. Box, City, State, and Zip Code. **Indicate if the address is a physical, mailing, or both and enter both addresses** if they are different.
- Enter the Participant's residence **phone number**.
- **If the demographic information changes**, such as an address, guardian name, or phone numbers, **you are required to update the electronic waiver system within seven days**.
- **Delete old information** – addresses, phone numbers, or email addresses when changes are made.

## Assessments [BACK TO INDEX](#) [ASSESSMENTS USER GUIDE](#)

### PURPOSE:

1. Use Waiver Application and Eligibility Guide as a reference tool for this section
2. Obtain approval from your PSS to get an ICAP (see instructions below)
3. Complete and upload the ICAP Authorization form
4. Enter the date you enter the LT-104 information & complete the LT-104 Services Needed
5. Verify the Participant has a qualifying diagnosis
6. Verify diagnosis matches a licensed psychologist or neurologist evaluation
7. Update licensed psychologist or neurologist evaluation data

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual Preferences
- Demographics
- **Assessments**
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization

Plan Dates: 1/1/2012 - 12/31/2012 (Future) IBA: \$28,000.00  
 Effective Date: 1/1/2012 (Renewal) Status: Approve Plan Of Care  
 Print: [Print Icon]

**Assessments**

Type	Evaluation Date	Status	Update	Express Update
LT 104		No Assessment on file	<a href="#">Update</a>	
Psych		No Assessment on file	<a href="#">Update</a>	
ICAP		No Assessment on file	<a href="#">Update</a>	<a href="#">Express Update</a>

### INSTRUCTIONS:

- Use the “Assessments History” link under Waiver Links to upload the Psych or Neuropsych evaluation and 3 pages ICAP report (if the ICAP data is not already in the EMWS).
- LT-104 is valid for one year.
- The Psych or Neuropsych and ICAP assessments are valid for five years. The ICAP is the only one that has an Express Update. Express Update means that you can transcribe the data from the current ICAP and enter it into the system.
- If the ICAP is older than five years or about to expire, you click “Update” to submit an ICAP request that your Participant Support Specialist (PSS) will review and if approved by your PSS, it rolls over to WIND to begin processing. (Refer to the [Waiver Application & Eligibility Guide](#) for these steps.)

## LT-104 Level of Care Assessment [BACK TO INDEX](#) [LT-104 USER GUIDE](#)

### INSTRUCTIONS:

- The **screening date** is the date you enter the LT-104 information in the EMWS.
- The **county** of the Participant’s physical address must be selected from the drop down menu.
- The diagnosis automatically may be populated from a previous LT-104. However, **you must double check to be sure the diagnosis matches the current psychologist or neurologist report.** If it does not match, correct it.
- **The individual must have a qualifying diagnosis to be considered eligible for a waiver.** For new applicants, enter a possible diagnosis then you can update it after you receive the official eligible diagnosis from a licensed psychologist or neurologist.
- **To be eligible for a waiver**, the individual is screened to assess if he/she **meets at least one criterion in either the Medical or Psychological column and at least one criterion in the Functional column for eligibility.**
  - If the individual has an 1) eligible diagnosis, 2) meets at least one criterion in either the Medical or Psychological sections, and 3) at least one criterion in Functional section, then you complete the “Action” step and submit the LT-104 in the EMWS to move it forward to your PSS for review and final determination for ICF/ID Level of Care.
- A new LT-104 must be submitted to the Division via the EMWS annually within 365 days of the previous LT-104 assessment, or with each new IPC, or when making a change to a different waiver program.

- **DFS is notified electronically when the Participant's IPC is renewing – you do not need to take a copy of the Participant's LT-104 to DFS;** they can access it directly through the EMWS. However, you may need to check with DFS to see if the Participant has submitted all necessary financial documentation. You can monitor your bottom task list to see where DFS is at in their part of this process.
  - **For a new applicant,** DFS is notified electronically when an individual has a funding opportunity and verifies financial eligibility.
  - DFS may request a copy of the funding letter. Please have it available if requested to take to DFS.
  - If a child is moving to an adult or ABI waiver program, DFS may also request a copy of the funding letter.
- For Participants on the waiver or new applicants, after you complete the LT-104 screening in the EMWS, the Division will make the final determination on ICF/ID Level of Care. (For new applicants, refer to [Waiver Application & Eligibility Guide](#) for more qualifying details.)

## Psychological/Neuropsychological Assessments

[BACK TO INDEX](#)

[PSY/NEURO USER GUIDE](#)

**Waiver Links**

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plans of Care](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

**Eligibility**

- ✓ [Create Application](#)
- ✓ [Select Case Manager](#)
- ✓ [Create Application](#)
- ✓ [Select Case Manager](#)
- ✓ [Complete LT 104](#)
- ✓ [Review Level of Care Assessment](#)
- ✓ [Financial Eligibility](#)
- ✓ [Submit Psych Evaluation](#)

**Action**

**Psych Evaluation**

**Document**

Please upload the Psych evaluation document.

**Document Information**

Evaluation Date

Psychologist Name

Non-standard IQ ☐

IQ

**Diagnoses**

**Neuropsych Evaluation**

**Document**

Please upload the Neuropsych evaluation document.

**Document Information**

Date Received

Evaluation Date

MPAT Score

California Verbal Learning Tests Trials 1-5 T Score

Supervision Rating Scale

Brain Injury Date

Brain Injury Cause

Injury Detail

☐ Alcohol Injury

### INSTRUCTIONS:

- Psychological/Neuropsychological evaluation must be completed and uploaded in the “Assessments History” link under Waiver Links. **90-days prior to the expiration of the evaluation, you will receive an email notification to schedule the next evaluation.**
- Evaluations are required to include 1) all related diagnoses, 2) the full scale IQ score or an indication of a non-standard IQ score, and be 3) signed and dated by a licensed Psychologist.
  - If you check non-standard IQ score, a box opens where you are required to document why there is no IQ score. Your IPC will be rolled back if this information is missing.
- **Evaluations also are required to include a minimum of three areas** of functional limitations from the following list:
  - Self-Care
  - Expressive and Receptive Communication
  - Learning
  - Mobility
  - Self-Direction
  - Capacity for Independent Living

- Once the evaluation is completed, **upload a scanned copy of the evaluation** using the [File Naming Convention](#) in the “Assessments History” link under Waiver Links.
- Regarding Neuropsychological qualifying scores for an **ABI waiver applicant or current Participant, the qualifying scores** are:
  - Mayo Portland Adaptability Inventory (MPAI) a Standard Score of 42 or greater (or)
  - California Verbal Learning Test, a T-score of 40 or less (or)
  - Supervision Rating Scale (SRS) of 4 or greater (or)
  - ICAP score of 70 or less
- **Psych or Neuropsych evaluations are completed every five years**, unless requested more frequently by the team and/or the Division and pre-approved by your Participant Support Specialist.
- **Recommendations from the Psychologist/Neurologist must be considered and incorporated in the appropriate sections in the IPC.** These sections could include the Needs, Risks, and Restrictions, Medical, and/or Behavioral Supports. See each section instructions for further details.
- If a Participant qualifies for waiver services because of a **related condition**:
  - The condition must be reflected in the psychological report and
  - Additional medical documentation by a physician or medical specialist must be uploaded in the “Document Library” link under Waiver Links
  - Refer to [Waiver Application & Eligibility Guide](#) for detailed definition of related condition
- If the Psychological/Neuropsychological evaluation expires before the next plan year, you can work with your Participant Support Specialist and submit a modification to have the evaluation pre-approved.
- **NOTE:** An out-of-date psychological or neuropsychological evaluation may impact continued funding.

## Inventory for Client and Agency Planning (ICAP) [BACK TO INDEX](#) [ICAP USER GUIDE](#)

### INSTRUCTIONS:

- The ICAP is an assessment tool to help provide information on identifying objectives and behavior supports.
  - If the ICAP was completed after February 2012, the data is already in the EMWS.
  - If the ICAP data is not in the EMWS, you must upload the three pages ICAP summary using the [File Naming Convention](#) in the “Assessments History” link under Waiver Links.
- After the initial ICAP, the **ICAP assessment is completed every five years** for all waiver Participants, unless requested by the team and/or the Division and pre-approved by your Participant Support Specialist.
- If the ICAP evaluation expires before the next plan year, you can begin working to identify respondents and start the ICAP process. **You upload names and contact information for two respondents. Include cell phone numbers** of respondents if available.
- Complete the [ICAP Authorization](#) form, which requires Participant/Guardian signature documenting permission for WIND to interview respondents for ICAP renewals. Upload this ICAP Authorization form under the first respondent using the [File Naming Convention](#). Then click the “Action” button to submit the ICAP to your PSS for review.
- **NOTE:** An out- of- date ICAP may affect continued funding.
- Review the [ICAP USER GUIDE](#) for specific details on when to use “Express Update” and “Update”.

## Circle of Supports

[BACK TO INDEX](#) [CIRCLE OF SUPPORTS USER GUIDE](#)

### PURPOSE:

1. Document the Participant's Home Setting
2. Complete the Participant's Circle of Support – contacts information must be kept current
3. Document Other Services Participant is receiving

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plan Enrollments
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan Mod Links**

- Plan Status
- Individual Preferences
- Demographics
- Assessments
- **Circle of Supports**
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

Plan Enrollment Dates: 4/1/2009 - 3/31/2010 (Inactive) IBA: \$80,065.00  
 Effective Date: 4/1/2009 (Renewal) Status: Complete  
 Print: [Print Icon]

**Circle of Supports**

**Home Setting**

☐ With parents ☐ Own home/apartment - alone  
☐ With extended family or friends ☐ Own home/apartment - with roommate(s)  
☐ Foster Home ☐ Residential habilitation home, with housemate(s)  
☐ SFHH ☐ Other

**Circle of Support**

There are no contacts in currently in Circle of Support. To add contacts, click Associate Contacts.

**Other Services**

☐ DVR ☐ Payee  
☐ Food Stamps ☐ Private Health Insurance  
☐ Housing Assistance ☐ PT  
☐ Indian Health Services ☐ School  
☐ Medicare ☐ Speech  
☐ Mental Health Services ☐ SSDI  
☐ OT ☐ SSI  
☐ Other ☐ Transportation Vouchers  
☐ Other Medicaid Plans

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### INSTRUCTIONS:

#### Home Setting Tab

- Check the appropriate home setting situation for the Participant. If “other” is the appropriate option, then a pop-up box will open where you enter a description explaining other.

#### Circle of Support Tab

- Contacts may be family members, relatives, neighbors, landlord, school supports, employment supports, natural supports, community members or agencies, local emergency agencies, doctors, therapists, Providers, DFS worker if Participant is a ward of the state, etc.

- If the contact is a guardian, you must first upload guardianship papers in “Contacts” under Waiver Links using the [File Naming Convention](#).
  - Anytime there is a change in Participant status for example, no longer has a Guardian or change in Guardianship, be sure to upload the current documentation.
- If the contact is a **Power of Attorney**, you must upload the Power of Attorney document using the [File Naming Convention](#) under the “Contacts” link.
- Enter the phone number and address for the contact person and remember to update the number and address of the contact if either changes. **You have 7 days after a change occurs to update the “Contact”** in the EMWS.
- **Advise the contacts they are on the Participant’s Circle of Support list**, unless they are a general community business or emergency agency.
- Be sure to **train the Participant on using his/her Circle of Supports** and provide Participant with a list of his/her contacts. Ensure this list is posted in a convenient and visible area in the Participant’s home as well.

### Other Services Tab

- Choose all services the Participant is receiving regardless of who is providing the funding (i.e. could be Department of Education, Department of Vocational Rehab, etc. providing funding – does not matter, check all the services that the Participant is receiving). If other is chosen, you are required to document what other refers to in terms of supports.



More details about **Building Natural and Paid Supports** at [BHD - DD Training](#)

## Needs, Risks, & Restrictions

[BACK TO INDEX](#)
[NEEDS, RISKS, & RESTRICTIONS USER GUIDE](#)

### PURPOSE:

1. Document 17 Support Area Assessments using “I” statements
  - a. Include applicable rights, restrictions, and restoration plans
  - b. Add comments – especially regarding any health & safety concerns
  - c. Upload guidelines and protocols for each applicable support area
  - d. Upload the required Habilitation Support worksheet
  - e. Upload orders for restraint under “Other” Support Area

**Needs, Risks, and Restrictions**

Assessments

Note: Hover over the each field to view detailed information. Comment on all areas.

Incomplete Assessments	Support Area	Support Type	Description	Protocols	Comment	Document
	Healthy Lifestyle					
	Community					
	Physical Conditions					
	Medications & Medical Regimen					
	Transportation					
	Housing					
	Communication					
	Self Care - Personal Hygiene, Bathing					
	Self Advocacy					
	Family & Friends					
	Other					
	Habilitation Supports					
	Financial & Property					
	Mobility					
	Employment/Employment Training					
	Vulnerability					
	Meal Time					

Upload Assessment

Please upload the Assessment form.

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### INSTRUCTIONS:

- Case Managers are required to apply the [Rights, Responsibilities and Restrictions](#) and to review this guide with the Participant and his/her Guardian every six months or as needed. As a tool, you can use the [Rights, Responsibilities, and Restrictions](#) worksheet to complete this section.
- **“Upload Assessment” tab** – is used to upload an organizations general assessment form that may cover multiple support areas. Otherwise, upload the guidelines and protocols in each support area under the “Assessment” tab as noted below.

- If there are formal guidelines or protocols used by the Provider, you are required to “Upload File” with the guidelines or protocols in the Modal screen for each Support Area. To get to the Modal screen, you click the pencil icon next to the support area and a Modal screen opens.
- For each Support Area in the Modal screen, document ‘How to assist the person in this area.’ In this area document all of the following that apply:
  - Guidelines provided in the psychologist or neurologist licensed evaluation
  - Identify any rights, restrictions, and then document a restoration plan that answers this question: “How will my team help me exercise my rights?” **Reminder – restrictions due to behaviors also must be included in your Positive Behavior Support Plan (PBSP).**
  - If you checked ‘High Risk area’, which indicates the Support Area would affect the health and safety of the Participant; **document the supports that will be used to keep the Participant safe and healthy.**
  - If a Participant has a Guardian or physical limitation that is limiting the exercise of his/her rights, explain the restriction then document the team’s plan to restore the Participant’s rights. If the right restriction is not due to behavior, enter “Right Restriction” in narrative box.
- The team is responsible for reviewing and documenting behaviors or conditions that pose a health and safety risk to the Participant in each applicable Support Area.
- Each Support Area must be completed using “I” statements. This could be as simple as the Participant stating, “I am independent in this area.” The team will document in each area the necessary detail needed to provide support to the Participant. If the support area is not applicable such as employment for a 3-year old; enter a brief statement such as, “I am going to school and too young for employment.”

- If you check “This assessment has protocols”, the **formal guidelines or written protocols need to be documented in the “Comments”** under the Protocol section. (For example: Mealtime guidelines, feeding protocol, special safety precautions, equipment guidelines, and diet and activity protocols.)
- NOTE: **Protocols do not automatically print when you click the icon to “Print IPC”**. Therefore, you may want to print the protocols individually and attach them to the IPC that you distribute to the team members.

## Details for each Support Area

### 1) Self Advocacy

- Specify how my family/guardian advocates for me.
- Explain how my guardian assists me with major life decisions such as housing, medical supports and Providers, choice of Providers, financial support, approved contacts, phone usage, or other issues.
- **Examples of self advocacy:** I can make my desires and concerns known to people who can fix them. Although I can make known my desires and concerns to people I know, I need total assistance advocating for myself.

- **Examples of restoration plan:** “If I am un-happy with a Provider, I can talk with my Guardian about helping me find a new Provider.” “I am not able to select Providers on my own; my Guardian makes the choices that are in my best interest.”

## 2) Transportation

- Include who may be providing me with transportation.
- **Examples of transportation:** I do not need assistance to transport myself. I use public transportation. I need transportation assistance to \_\_\_\_\_ activities (specify the activities).

## 3) Housing

- **Examples of housing:** The health and safety of me or others is at risk due to the following behavior(s) in my home or Provider’s facility \_\_\_\_\_. (List behaviors such as elopement, exploitation, aggression, pica, etc.) My team will help me be safe in my home by \_\_\_\_\_. (Describe the strategies to minimize the occurrence of risky behavior and identify special accommodations or items used to help me be safe, etc.)
- **Examples of restoration plan:** “I can talk with my Guardian about where I want to live and whom I want to live with.” “I am not able to leave my home without supervision.” “I am free to decorate my room how I like and my Guardian listens to me if I have likes or dislikes I want addressed.” “I have poor mobility, so I require supervision to ensure my safety and well-being.”

## 4) Employment/ Employment Training

- Describe any supervision and accommodations I need during work or training.
- **Examples of employment and training:** The work I do \_\_\_\_\_ (describe), my average work hours a day are \_\_\_\_\_ and I work at \_\_\_\_\_. My work is considered \_\_\_\_\_. (Independently Employed, Individual Community Integrated Employment, Group Supported Employment, Part of a Habitation Objective) I am not competitively employed.

## 5) Mobility

- Positioning and/or transfer needs: give directions for positioning, transfers, and frequency.
- **Example in the Mobility area:** I am at risk of falling when I first stand up. The safety plan may be: Staff will teach/remind me to ask for assistance before standing. I will hold a staff’s arm when getting up and hold on to staff or furniture during the first few steps I take.
- **Examples of mobility:** I can walk independently. I can walk with assistance or \_\_\_\_\_ assistive equipment (specify type of equipment). I use a wheelchair \_\_\_\_\_ (specify part or all of the time). I have a high risk of falling or being unsafe when walking, so they try to keep me safe by \_\_\_\_\_ (specify).

## 6) Meal Time

- Meal time represents formal guidelines or protocols that have been developed by a physician, nurse, dietician, or speech therapist to assist the Participant with safe eating protocol. Such as: uses a feeding tube, has swallowing problems, has a meal time plan created by a therapist, aspiration risk, etc. Upload the protocol.
- Dietary questions address formal nutritional guidelines from those identified above or they can be informal guidelines that the team has determined; such as the Participant does not like pasta or the Participant wants to be on a diet eating less carbs.
- Guidelines may be in place for health reasons, such as restricted calories due to obesity, diabetic diet, doctor-ordered diet, etc. Document the reason for these guidelines.
- If Participant has no choice in the diet, this should be documented as rights restrictions under the “Right, Needs, Restrictions” link and include a restoration plan.
- **Examples of meal time:** I can prepare my own meals independently. I can eat independently. I have no dietary restrictions. I can prepare meals with assistance. I need assistance in making healthy food/drink choices. I need assistance to eat safely. (Document any drink or dietary instructions/restrictions.)
- **Examples of restoration plan:** “I am restricted to access my personal snacks because of another’s restriction. However, I now have my own cupboard and a key to access my snacks whenever I want them.” “I can access my snacks in my room.” “My team is working with me to help me learn how to make healthy food choices.” “I require supervision when I eat so I don’t overeat.”

## 7) Financial & Property

- Specify if Participant has a representative Payee and identify who is the Payee. Be sure to add the Payee contact information in “Contacts” under Waiver Links.
- **Examples of money transactions:** I can manage and budget my money independently. I need assistance with budgeting and check writing. I can keep up to \$\_\_\_\_ on my person. I can exchange money for purchases.
- **Examples of rights restrictions:**
  - a. Possessions (specify such as food and personal items) are locked-up by the Provider.
  - b. Access to cigarettes, chewing tobacco, or alcohol is limited – even if it is for health reasons.
  - c. There is a temporary removal of possessions, such as clothing, bedding, games, toys, books, crafts, movies, CDs, etc. for behavioral modification purposes.
  - d. Personal possessions are specifically locked-up per Participant’s request.
  - e. Possessions have guidelines for use determined by the Participant or Guardian.
- **Examples of restoration plan:** “My mother is my Payee so I have a restriction on the availability and amount of money I can have. Now I can have \$20 a week to spend at the mall.” “I can carry \$35 on my person and use this money to make purchases with staff assisting me in my spending decisions.” “I do not have the cognitive skills to understand the value of money and use it responsibly; future improvement is not likely and my Guardian will pay my bills and make my

financial decisions.” “Staff hand me my money when I make a purchase so I can begin to understand what money is used for.”

“After several chances, if I can demonstrate I have calmed myself down then I am allowed to have my cigarettes and smoke.” “I can play my video games for 2 hours when I demonstrate responsible behavior handling the equipment properly.”

## 8) Physical Conditions

- Describe the support needs, any equipment used, or any special environmental supports. This could include safety risks in the home.
- Document specific support and safety precautions.

## 9) Communication

- **Examples Communication:** I can verbally communicate. I communicate using \_\_\_\_\_ (gestures, sounds, sign language, communication device, etc.) I need someone to communicate for me. Assist me communicating by \_\_\_\_\_ (explain).
- **List in this section if the right to make and receive telephone calls is restricted due to:**
  - a. guardian request
  - b. Agency policies; such as calling while at work, times that calls are allowable, payment for calls, use of cell phones, etc.
  - c. behavioral issues
- **Examples of restoration plan:** “I am allowed to use the telephone in private when I demonstrate I understood I am to only dial 911 for emergencies then my phone restriction is removed.” “I can make phone calls if I stay at 10 minutes.” “I can open my mail when I receive a card from someone I know.”

## 10) Family and Friends

- **Examples of family and friends:** I have the right to receive visitors, communicate, and associate with persons of my own choice.
- Document if a restriction is due to behavior that is a court order, custodial right, or condition of probation.
- Document if the Participant has an approved visitors list.
- Document if due to behavioral issues, the choice of others in the home is restricted.
- **NOTE:** IPCs of the others in the home may need to have a right restricted if a restriction of visitors limits their right as well.
- **Examples of restoration plan:** “I can receive a visitor and communicate with persons of my choice after my Guardian or Provider meets them.”

## 11) Self Care - Personal Hygiene & Bathing

- **Examples self-care:** I can use the toilet independently. I can be alone \_\_\_\_\_ (specify how often) with visual or auditory checks. I need someone to wait outside the door. I need verbal prompts \_\_\_\_\_ (specify how often) for toileting. I need \_\_\_\_\_ (specify instructions) assistance with toileting, pericare, or during menses. I require medical equipment \_\_\_\_\_ (document type) supports in the bathroom.
- **Examples personal hygiene:** I can do this independently. I use checklists or other reminders for \_\_\_\_\_ (document specifics). I need assistance with \_\_\_\_\_ (document specific support or safety protocols). Other comments \_\_\_\_\_.
- **Examples of restoration plan:** “I may require assistance with bathing such as scrubbing, rinsing off my hair, or towel drying. My Provider can wait outside the bathing area and I will tell them if they need to provide me with assistance in these areas.” “I can have privacy when I can demonstrate I will not hurt myself or others.” “I receive total care with hygiene from staff except hand washing that I can do independently.” “I need to be monitored when I am using the restroom and receive assistance from my team with peri-care.” “I have physical limitations and staff assist me with all hygiene care.” “My team helps me with bathing in case I have a seizure.” “Although I require total hygiene assistance, staff always assists me in the privacy of my room.”

## 12) Habilitation Supports

- For Residential and Day Habilitation services, you must explain the supervision levels for the Participant.
- The [Habilitation Support](#) worksheet is required to be uploaded in this section. You and Division staff will use this document to monitor staffing patterns.
- **Examples habilitation supports:** On a typical day my usual support is \_\_\_\_\_ (Intensive 1:1, high 1:2, moderate 1:3, or intermittent 1:4). I can have less support when \_\_\_\_\_ (in my room, watching TV, doing sedentary activities, etc.). I need closer support when \_\_\_\_\_ (as documented in my Positive Behavior Support Plan, during personal care, mealtime, community outings, etc.).
- **More examples habilitation supports:** During critical care times or crises, this is how my support needs and supervision should change and how the extra assistance should be accessed: \_\_\_\_\_. During sleeping hours or positioning times I will be monitored \_\_\_\_\_ (checks every \_\_\_\_ minutes). If I receive Intervention Hours, \_\_\_\_\_ (specify residential and/or day habilitation usage, how the additional staff person for intervention is accessed, and what the intervention will be utilized for).
- **For other habilitation services** - Child Habilitation, Special Family Habilitation Home, Residential Habilitation Training, Supported Employment, and Supported Living describe these staffing supports for the Participant.

## Support/Supervision Levels for Habilitation

Use to determine the most accurate tiered support/supervision level and rate.

1. Residential Habilitation and Day Habilitation have tiered support levels and rates. A detailed description of support levels must be uploaded in the Habilitation Supports section on the “Needs, Risks, and Restrictions” link using the [Habilitation Support](#) worksheet.
2. For services that have tiered rate based on support levels, the Participant’s ICAP Service Score is a starting point to determine the appropriate tiered rate. The ICAP Service Score does not guarantee a supervision level. It is important for a Participant’s habilitation Providers and team to discuss the supports needed and compare those with the [Support Level Descriptions](#) to determine the appropriate level for the service.
3. Descriptions of the tiered support levels are shown in [Figure A-1](#). This table describes the average support expected for each tier.
  - a. As described in [Figure A-1](#), it is expected that a Participant will receive some intensive support and assistance, as needed, regardless of the service setting.
  - b. A detailed description of support needed during typical days and during times of extraordinary need or crises is required to be documented in the “**Habilitation Support**” under the Need, Risks and Restrictions” link.
4. If the Participant has moved into a less restrictive living arrangement, such as moving from a group home to an apartment, the IBA may be revised to reflect a less intensive level of support needed.
5. If a higher tier of support was approved by the Division on the last IPC, the same support tier will be approved on the new IPC as long as the IPC continues to substantiate that support need. You do NOT need to submit a new request.
6. If the Participant requires higher support than in his/her previous IPC, a [“Supervision Level and/or Intervention Request”](#) form must be submitted and the IPC information must substantiate the support tier requested.
  - a. [Instructions](#) for completing this form can be found under the “Supplemental Forms”.
  - b. If the request for additional support exceeds the IBA, you are required to submit an [Individual Budget Amount \(IBA\) Adjustment Request](#) form to the Division 40 calendar days before the intended IPC start date for review. **Support tiers are subject to approval by the Division.**

Refer to the [ICAP Service Level Support](#) for further details.

Refer to the [Guidelines for Adjustments to Support Levels and/or Intervention Units](#) for specifics.

ICAP Service Score Range	<b>Figure A-1</b>  <b>SUPPORT LEVEL DESCRIPTION</b>  <b>(ICAP Service Score is a starting point to determine the appropriate support needed)</b>	Support Level
<b>1-22</b>	<p><b>Intensive Support</b>—Intense levels of support for an individual, who has any one or more of the following: (1) Critical medical needs where intensive, ongoing support is essential for sustaining health and well-being; or (2) Total and frequent personal care needs; or (3) Severe and persistent behaviors needing intensive, ongoing support and intervention, occasionally from one or more additional direct care workers. This level of support is provided in almost all circumstances during waking hours and as needed basis during sleeping hours. This level should not be used for a participant that requires <i>periodic</i> intense support.</p> <p>For participants with critical behavioral needs, the staffing expectation for this intensive support level may increase and decrease depending on times of stability (when less support is appropriate) and times of crisis (when staffing may need to be 2:1 or higher to keep the person and others safe). The support and staffing variances for these participants shall be outlined specifically in the plan of care with prior approval by the Division. The provider is expected to review the staffing required for the person regularly and propose a less intensive support level if the person is making progress.</p>	<b>Intensive</b>  <b>1:1</b>
<b>23-49</b>	<p><b>High Support</b>—Support for an individual, who requires frequent verbal prompting or guidance, physical assistance for specific activities (i.e. eating, dressing, or bathing, or community outings), periodic intensive or high support, because of severe and persistent behaviors where some physical intervention may be needed at times. Staff is within a safe proximity at all times as specified in the plan, supporting two participants during most of the day. This level assumes that the direct care worker will be available to provide specific support as specified in the plan of care, be responsive to a person’s needs during relaxed times and more intense situations, and as needed during sleeping hours.</p>	<b>High</b>  <b>1:2</b>
<b>50-64</b>	<p><b>Moderate Support</b>- Some physical assistance or support with other activities of daily living, and direct support while in certain habilitation and community activities. The participant may have indirect support with a direct care worker available in another room or available by phone for brief periods during sedentary activities, as specified in the plan of care. The participant is able to accomplish most activities of daily living through verbal assistance or by utilizing checklists, and respond to verbal redirection for behavioral concerns. The individual may receive some intensive support as specified in the plan. Staff is within a safe proximity at all times as specified in the plan, supporting three participants during most of the day in the habilitation service. The direct care worker will be available to provide sufficient periodic intensive or high support to the participant during the day per the plan of care and as needed during sleeping hours.</p>	<b>Moderate</b>  <b>1:3</b>
<b>65 or above</b>	<p><b>Intermittent Support</b>- Periodic support for an individual, who is able to manage most activities of daily living independently, but may need periodic verbal prompting, monitoring, support, or assistance. The Individual may have some periods of unsupervised time at home or in the community and receives limited intensive support, as specified in the plan of care. There is one Direct Care Worker supervising four participants during waking hours in the habilitation service. This tier assumes that a direct care worker is available on-site per the plan (24 hours a day, if needed) to provide sufficient periodic intensive or high support and monitoring to the participant as needed per the plan.</p>	<b>Intermittent</b>  <b>1:4</b>

<b>Figure A-2</b>	<b>Guidelines for Adjustments to Support Levels and/or Intervention Units</b>
<b>Behavior</b>	<p>A Participant may need additional support/intervention for community outings due to aggression, elopement, inappropriate/illegal conduct, pedophilia, court-ordered supervision. If the Participant has a history of these behaviors, there should be a Positive Behavior Support Plan in the Individualized Plan of Care (IPC) that addresses the need for extra staff or intervention hours to implement the support, which prevents or minimizes the likelihood of the above-mentioned behaviors occurring. The support or intervention is not intended for purposes of watching the Participant should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the Participant safe.</p> <p>A Participant may need intensive support with more than one extra staff during predictable episodic behaviors that happen occasionally or somewhat regularly. To the extent these episodes are predictable; they should be addressed in the IPC.</p>
<b>Health</b>	<p>A Participant may need additional support due to increased health needs. If a Participant usually functions well with a high support level or in a less intensive setting during healthy times, but needs intensive support occasionally due to increased health needs, then this need should be described in the IPC. If the request is due to a temporary change in a Participant's physical well being due to illness or accident, the justification should include the projected timeline and prognosis for recovery/remediation from the illness or accident and the specific support that will be implemented during this time. The authorization of additional staff or intervention should be time limited and monitored to determine the ongoing need.</p>
<b>Safety</b>	<p>Staff support/intervention for community outings, activities in the residential or day setting may be necessary due to mobility issues that necessitate intensive or high support. The frequency and need should be specified in the IPC and should specify the role of additional staff intervention.</p>
<b>Medical</b>	<p>Surgery/injury/rehabilitation time – temporary intensive support when person is in recovery (Intervention request would come in as a modification). Need may be due to a temporary change in a person's physical well being due to a medical condition – in these instances, justification should specify the health need being addressed and the specific interventions to be provided. The authorization should be time limited and monitored to determine the ongoing need.</p>
<b>Personal Care</b>	<p>A Participant receiving a moderate or intermittent support level may need additional staff intervention periodically during the day for intensive mealtime, bathing, personal care, or pericare that is in addition to the supports included in the IPC. If additional support or intervention is required, then the IPC should specifically identify the activities of daily living that require support to meet the specified personal care need.</p>

### 13) Other

- Restraint usage is listed under “Other”. An order for the use of a restraint by a physician or designated, trained, and competent qualified behavioral health practitioner with prescription authority is required to be uploaded in the “Document Library” under Waiver Links annually. **Restraints listed in the Positive Behavior Support Plan must also be documented under “Other” Support Area in the “Needs, Risks and Restrictions” link.**

1. **Mechanical restraint:** Any device attached or adjacent to a Participant’s body, which he or she cannot easily remove, and restricts freedom of movement or normal access to the body.
  - a. List as restricted due to behavior, if the mechanical restraint is:
    - An item such as weighted blanket/vest/body sock and it cannot be removed by the Participant, unless the item is used in an approved therapeutic program.
    - A lap belt, strap, glove, or other item, which restricts movement of the body due to behavioral considerations and Participant, cannot remove the item.
  - b. Do not list as restricted due to behavior for the following mechanical restraints, if used for standard safety reasons, such as:
    - Seatbelt/car seat
    - Wheelchair lap belt
    - Specialized harness, car seat for adult, safety belt, head supports, bed rails, etc.
2. **Physical/Personal Restraint:** Means the application of physical force without the use of any device, for the purposes of restraining the free movement of the body of the Participant.
  - a. List as restricted due to behavior, if a physical restraint or release is used.
  - b. Do not list as a restriction but a “community support”, if the action is:
    - Holding a person’s hand to cross the street safely
    - Helping a person get in to or out of a place
3. **Chemical Restraint:** A drug used in a crisis situation to prevent or limit a Participant’s challenging behavior and to protect a Participant from seriously harming his/ her self or others.
  - a. An order for the chemical restraint is required from a medical professional with prescribing authority.
  - b. If there are three or more instances of a chemical restraint being used in six months, a formal medical review of the Participant must take place by the prescribing authority and the team to determine if the treatment plan, behavior plan and/or the IPC needs to be changed.

- Restraints must be in compliance with [Chapter 45](#), Section 28, including:
  - a. The least restrictive intervention techniques, which should be used prior to the use of restraint.
  - b. Any limitations or specific descriptions of the proper restraint to use or not use on the Participant.
  - c. The designated staff to provide face-to-face evaluation of the Participant within one hour of the use of restraint.
  - d. Providers must receive training on the use of restraint from entities that are certified to conduct such training before agreeing to Provider services for that Participant.
- **Examples of restoration plan:** “If my behavior is leading to self-abuse or harm toward others, staff will use a CPI or MANDT/non-violent restraint technique until I calm down.” “My family will re-direct me so I do not hurt myself or others and restraints are not necessary.”

#### 14) Community

- **Example community:** The health and safety of myself or others is at risk due to the following behavior(s) in public places \_\_\_\_\_: (document items such as falling risks, quick to develop sun burns, elopement, exhaustion, vandalism, aggression, illegal activity, etc.)
- **In the protocols section:** My team will help me be safe in these situations by \_\_\_\_\_: (Describe the strategies to minimize the occurrence of risky behavior, special accommodations or items used to help me be safe.)
- If the Participant is prevented from going into the community as a consequence of a maladaptive behavior, this is a rights restriction.
  - a. When the Positive Behavior Support Plan (PBSP) includes a restriction from community activities, it must:
    - 1. Not exceed 36-hours unless the PBSP includes information from a psychologist on the health, safety, or therapeutic reasons for a longer restriction.
    - 2. Include opportunities for the Participant to reduce the length of time of a restriction.
- NOTE: Restrictions cannot be applied to employment unless they are due to health and safety concerns.

#### 15) Healthy Lifestyle

- Include things like drinking more water, exercise options, choosing healthy snacks, seeking better habits, etc.
- Explain if assistance or monitoring is needed during sleeping hours to stay safe.
- **Example healthy lifestyle:** During critical care times or crisis, this is how my support need and supervision should change and how the extra assistance should be accessed \_\_\_\_\_ (explain). These are listed in the [Planning Workbook for Individualized Plans of Care](#).

## 16) Vulnerability

- **Examples Emergency Situations:** I can evacuate independently. I can evacuate independently but I need these \_\_\_\_\_ verbal prompt(s). I need physical assistance by another person \_\_\_\_\_ (specify person). I need total assistance by another person \_\_\_\_\_ (specify person).
- **Examples Special Safety Precautions:** The health and safety of me or others is at risk due to the following: \_\_\_\_\_. (Document such as elopement, exploitation, relationships, sexual, mail, Internet, aggression, pica, etc.)

## 17) Medications & Medical Regime

- Verify the assistance, if any, is needed by the Participant to take medications.
- Specific medication protocols (i.e. Participant needs to take medications in apple sauce; medications need to be locked-up in the home, etc.).
- Provider who administers medications must have a Skilled Nurse or valid Medication Assistance Certificate. This must be available upon request for you to review.
- You may obtain a release of information form so that you can discuss medical issues with the Participant's physician. Your organization is responsible for developing a release form and you keep this form in your own files. You do not upload a copy to the Division but do have it on hand if requested for review by a Provider Support Specialist.
- **Examples of restoration plan:** "If I am unhappy with my medical services, I can talk with my Guardian about my choices." "If I am ever in danger of being exploited, it would be my Guardian's responsibility to find me a new medical services/provider." "My guardian asks me my opinion about health issues then he/she makes the final decision that is in the best interest of my health." "If my Guardian sees that I am visibly agitated with a Provider or when going to see a Physician, he/she will explore other possible Providers or Physicians."

## Important Note Regarding Child Waiver Restrictions

For waiver services provided for a child under 18 years of age, list Rights and Restrictions when any of the following conditions are present:

1. Child is 8 or older needs assistance in self-care
2. Child is 8 or older has a video or auditory monitor in the bathroom or bedroom
3. Any age Child has a Positive Behavior Support plan that lists behavior restrictions Providers would be expected to carry out

## Medical [BACK TO INDEX](#) [MEDICAL USER GUIDE](#)

### PURPOSE:

1. Document Participant’s medications or upload Medication Assistance Record
2. Utilize “My Medical Services” worksheet to keep track of appointments & immunizations
3. Upload Medical Consent form
4. Document any known allergies

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plan Enrollments
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan Mod Links**

- Plan Status
- Individual Preferences
- Demographics
- Assessments
- Circle of supports
- Needs, Risks, & Restrictions
- **Medical**
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

**Plan Enrollment Dates:** 4/1/2009 - 3/31/2010 (Inactive) **IBA:** \$80,065.00

**Effective Date:** 4/1/2009 (Renewal) **Status:** Complete

**Print:**

**Medical**

**Medical Professional**

No medical professional found.

**Add**

**Diagnoses**

No diagnosis found.

**Add**

**Medications**

No manually entered medications found.

**Add**

No medication documents found.

Upload medication documents:

**Browse...**

**Known Allergies/Serious Reactions**

☒ No Known Allergies

**Cancel**

errors on page. Trusted sites

### INSTRUCTIONS:

- You are responsible for assuring Participant obtains regular medical treatment, including immunizations, annual assessments, blood work, etc. You must keep a schedule of medical appointments. [My Medical Services](#) worksheet is available to assist you with this documentation.

### Medical Services Tab

- From your contacts, the medical professionals will automatically be populated in this area. If someone is missing, you can click “Add” to include them here or add them in “Contacts” under Waiver Links – either link can be used to add/modify contacts.

### Diagnoses Tab

- These diagnoses are automatically populated from the ICAP and Psychological/Neuropsychological assessments. You may need to add additional medical diagnoses that are important for the team to know.

### Medications Tab

- Add all medications the Participant is taking in this section or upload the [Medication Assistance Record](#) (MAR).
- When adding medications, you will be prompted to identify the assistance required. You are required to upload the [Medication Consent](#) form under the “Medications” tab by clicking Browse.
- This medications list can be updated at any time
- Be sure to spell the medication correctly.
- Some Case Managers are not entering all the medications, opting instead to complete the [Medication Assistance Record](#) and upload this document. This allows Providers to have more specific information. A new MAR can be uploaded whenever there are medication changes.

### Known Allergies

- Check all known allergies. After you check an allergy, you will see a drop down menu where you can document serious reactions or other important notes. If a protocol is more appropriate, include it under the “Needs, Risks, and Restrictions” link.

## Specialized Equipment [BACK TO INDEX](#) [SPECIALIZED EQUIPMENT USER GUIDE](#)

### PURPOSE:

1. Add all equipment purchased with Medicaid or public funds
2. Add all equipment no longer in use and specify why

The screenshot displays the 'Medicaid Waiver System' interface. At the top, there is a navigation bar with tabs: 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. Below this, a header section shows 'Waiver: DDD - Child', 'Participant: McNichols, George', and 'Case Manager: Aiken, Kirsten'. The main content area is divided into two columns. The left column contains a 'Waiver Links' menu with items like 'Case', 'Waiver', 'Participant', 'Contacts', 'Associated Users', 'Plans of Care', 'Individual Budget Amount', 'Letter History', 'Document Library', 'Assessment History', 'Processes', 'Targeted Case Management', and 'Notes'. Below this is a 'Plan of Care Links' menu with items like 'Plan Status', 'Individual', 'Demographics', 'Assessments', 'Circle of Supports', 'Needs, Risks, & Restrictions', 'Medical', 'Specialized Equipment' (which is circled in red), 'Behavioral Supports', 'Service Authorization', and 'Verification'. An arrow points from the 'Specialized Equipment' link in the left menu to the 'Specialized Equipment' section on the right. The right section has a title 'Specialized Equipment' and a sub-header 'Specialized Equipment'. Below this, there is a text box containing 'No specialized equipment found.' and an 'Add' button. At the bottom of the right section is a 'Save' button. The footer of the page includes the Wyoming Department of Health logo and the text '© 2011 Wyoming Department of Health. All rights reserved.'

### INSTRUCTIONS:

- If the Participant does not have Specialized Equipment, do not complete this section.
- Add all equipment purchased with Medicaid Waiver or public funds within the last IPC year along with any equipment still in use.
  - ✓ For example, if a wheelchair was purchased with Medicaid funds three years ago and is still in use, it needs to be added.

- ✓ If glasses were purchased with private insurance and are still in use, this needs to be included.
- ✓ Add any needed adaptive equipment/assistive technology and the action plan and time frames for requesting and obtaining this equipment.
- ✓ Add equipment that is no longer a benefit and state the reason why.

**NOTE:** The Weston Center is one of several that accept donated equipment. Equipment at the Center is also available for any Wyoming citizen to check out.

## Behavioral Supports

[BACK TO INDEX](#)

[BEHAVIORAL SUPPORTS USER GUIDE](#)

### PURPOSE:

1. Add Functional Assessment details
2. Add Positive Behavior Support Plan
3. If modifying an ICAP Targeted Behavior, document the reasoning

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual
- Demographics
- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- **Behavioral Supports**
- Service Authorization
- Verification

**Behavioral Supports**

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care

Enrollment: 11/9/2011 - 11/8/2012 (Future)

**ICAP Targeted Behaviors**

Behavior Category	Response	Included?	Not included Reason
Unusual or Repetitive Habits	Moderate	Yes	X
Withdrawal or Inattentive Behavior	Moderate	Yes	X

Add

**Positive Behavior Support Plans**

There are no Positive Behavior Support Plans.

Add

### INSTRUCTIONS:

- If the ICAP assessment includes problematic behaviors at the moderate, serious, or critical level, the EMWS automatically includes these ICAP Targeted Behaviors in the “Behavior Supports” link.
- If problematic behaviors at the moderate, serious, or critical level are included in this section, you are then prompted to **include a Positive Behavior Support Plan (PBSP)**. This is a sample [Positive Behavior Support Plan](#) but you are not required to use it; this is a tool to help guide you in the process.
- **The team completes a PBSP based on a Functional Behavior Assessment.** The [Functional Assessment](#) can be used to help guide the team thinking why the behavior might be here in the first place versus just restricting a Participant as a means to control his/her behavior.

**ICAP Targeted Behavior**

Behavior Category:

Response:

☐ Included in behavior plan

☒ No behavior plan needed

Indicate the reason no behavior plan is needed:

**Document**

- If the team no longer considers an ICAP Targeted Behavior moderate or above, click the pencil icon next to the behavior and click “No behavior plan needed” in the Modal screen that opens illustrated above.
- Then document in the comment box on the above screen why no behavior plan is needed.

- PBSP is uploaded in the “Behavior Supports” link under Add - Positive Behavior Support Plans tab.
- Complete this checklist and upload the PBSP.
- Review and comply with the section below on the requirements for a PBSP.

**Positive Behavior Support Plan**

Topics addressed in plan (check all that apply)

☐ Directions for provider

☐ Information based on the functional behavioral analysis of targeted behaviors

☐ Positive behavioral supports

☐ PRN information for behavioral modification (if applicable)

☐ Protocol for documenting observed targeted behaviors

☐ Replacement behaviors

☐ Review protocol

☐ Therapeutic actions/interventions

Restrictions (check all that apply)

☐ Communication ☐ Community

☐ Possessions ☐ Privacy

Restrictions (check all that apply)

☐ Mechanical

☐ Physical

Comments

Document

## **Positive Behavior Support Plan (PBSP) Requirements**

- **PBSP is developed for the following reasons:**
    - a. Any behavior listed as moderate or above the current ICAP
    - b. Specific behaviors identified by the team or psychologist that need to be changed or eliminated
    - c. Behaviors identified as health and safety concerns
    - d. Behaviors identified as barriers to gaining independence, employment, or positive social interactions within the community
  - The team is required to address possible medical reasons for the behavior in the PBSP.
  - The team and/or psychologist may draft a PBSP to address any behavioral concerns of the Participant, in which case, you can consult with the psychologist when needed or if the team is having trouble designing a PBSP.
  - You are responsible for assuring Providers are trained on the PBSP **before** they begin working with the Participant.
  - The ICAP Targeted Behaviors may be prioritized in your PBSP by first addressing the most critical or important behaviors then others addressed as needs change.
  - **PBSP is required to:**
    - a. be person-centered
    - b. have the Participant involved in the development on a level appropriate for Participant
    - c. maintain the dignity and respect of the Participant
- PBSP is required to include the following applicable 10 steps:
    1. **Information obtained from the teams functional behavioral analysis of targeted behaviors, including the following components:**
      - ✓ Brief history of the Participant as related to the identified behaviors
      - ✓ Descriptions of direct observations of behavior
      - ✓ Information on antecedents to targeted behaviors that Providers are aware of so they can intervene and/or assist the Participant in replacing the targeted behavior with a replacement behavior
      - ✓ Information on baseline data collected, if possible, which more thoroughly describes the targeted behaviors, including frequency, severity, etc.
      - ✓ Identification of replacement behaviors or approaches that assist the Participant in getting his/her needs met in an appropriate way
      - ✓ **Functional Behavior Analysis document can be uploaded** under the Positive Behavior Support Plans tab by clicking “Add”.  
NOTE: The Functional Behavior Analysis does not have to be uploaded but it should be available if a PSS requests to see it.
      - ✓ Several documents can be uploaded under the “Positive Behavior Support Plans tab” including the teams Functional Behavior Analysis and the PBSP.

2. **Targeted Behaviors**

- ✓ Description of each targeted behavior and its brief history
- ✓ Reason the team believes a targeted behavior occurs

3. **Directions for Provider**

- ✓ To recognize antecedents and emerging targeted behaviors
- ✓ To intervene in a positive, least restrictive, and most effective manner when targeted behavior emerges

4. **Positive Behavioral Supports**

- ✓ Statements or cues staff should use to communicate and/or intervene with the Participant
- ✓ Actions to assist the Participant in replacing targeted behaviors with replacement behaviors
- ✓ Strategies to pre-teach or model actions before an event or environment so targeted behaviors can be prevented
- ✓ Preventative measures staff can take to adjust the environment once preliminary behaviors are displayed. (Such as changing rooms, turning off noisy items, distancing other people from the person, removing the person from a problem event, etc.)
- ✓ Positive intervention steps staff should try once the preliminary behavior is exhibited (Such as key phrases, options, choice for/modifying/ending an activity)
- ✓ Cues to introduce tasks or choices that promote replacement behaviors

- ✓ Determine what the Participant is trying to communicate through his/her behavior and try to meet the Participant's needs. (Such as taking him/her to the bathroom, giving him/her time to calm down, offering a change in environment, modeling appropriate attention seeking behavior, etc.)

5. **Replacement Behaviors**

- ✓ A more desired behavior the Participant should do instead of the targeted behavior
- ✓ Directions to teach, model, or prompt the Participant to initiate the replacement behavior

6. **PRN Information for Behavioral Modification** (if applicable)

- ✓ If PRNs are listed on the “**Medical Information**” link and are used to handle behavioral issues, then the PRN protocol in the PBSP should include:
  - Who notifies appointed person to assess the Participant for a PRN
  - Who administers the PRN
  - Who monitors the Participant for side-effects after it is taken
  - How the PRN is documented and
  - Who analyzes the use of the PRN

7. **Restraints**, if necessary

- ✓ An order for use of restraint by a physician or designated, trained, and competent qualified behavioral health practitioner must be submitted at least annually

- ✓ **Restraints listed in the PBSP must also be included on the “Needs, Risks, and Restrictions” in “Other” Support Area**

- ✓ Restraint usage must be in compliance with Chapter 45, Section 28, including:
  - The least restrictive intervention techniques, which should be used prior to the use of restraint
  - Any limitations or specific descriptions of the proper restraint to use or not use on the Participant
  - The designated staff to provide face-to-face evaluation of the Participant within one hour of the use of restraint
  - Providers are required to receive training on the use of restraint from entities that are certified to conduct such training before agreeing to provide services for that Participant

#### 8. **Therapeutic actions/interventions**

- ✓ Provider actions that should occur following the targeted behavior and
- ✓ Note when the actions/interventions must occur

#### 9. **Review**

- ✓ Protocol for who will review plan quarterly for effectiveness and who will revise the behavior plan as necessary

#### 10. **Documentation describing**

- ✓ Tracking the occurrence of targeted behaviors
- ✓ Tracking results of positive behavioral interventions
- ✓ Tracking use of PRNs, restraints, and restrictions
- ✓ Dates and times of the occurrence of the targeted behavior
- ✓ Description of the antecedents to the targeted behavior
- ✓ Trend analysis on the behaviors and incident report information
- ✓ When behavior support plans include rights restrictions, the IPC must include information on temporarily lifting the restriction during times of personal crisis, when appropriate
  - Times of crisis may include a funeral, family emergency, health concern, etc.
- ✓ When the behavior plan includes a restriction from community activities:
  - Not to exceed 36-hours unless the IPC includes information from a psychologist on the health, safety, or therapeutic reasons for a longer restriction
  - Include opportunities for the Participant to reduce the length of time of a restriction

## Service Authorization [BACK TO INDEX](#) [SERVICE AUTHORIZATION USER GUIDE](#)

### PURPOSE:

1. Ensure IPC is not over the allotted IBA
2. Complete the Service Authorizations
3. Upload all supporting documentation for services where documentation is required
4. Goals align with the Participant's desired accomplishments in the "Individual Preferences"
5. Upload the Goods & Services/Unpaid Caregiver Training documents if Self-Directing

#### Waiver Links

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plans of Care](#)
- [Individual Budget Amount](#)
- [Letter History](#)
- [Document Library](#)
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- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

#### Plan of Care Links

- [Plan Status](#)
- [Individual](#)
- [Demographics](#)
- [Assessments](#)
- [Circle of Supports](#)
- [Needs, Risks, & Restrictions](#)
- [Medical](#)
- [Specialized Equipment](#)
- [Behavioral Supports](#)
- [Service Authorization](#)
- [Verification](#)

**Plan:** 11/9/2011 - 11/8/2012 (Initial) **Status:** Submit Plan Of Care

**Enrollment:** 11/9/2011 - 11/8/2012 (Future)

### Service Authorization

**Vision:** N/A

**Preferences:** N/A

**Important Things to Know:** N/A

### Waiver Services

**IBA**

Individual Budget Amount: \$12,000.00

Traditional Services: \$0.00


Self-Directed: \$0.00

---

Amount Remaining: \$12,000.00

**Services**

Note: Hover over the Service Code to view the full service name. Hover over the icon in the goal column to view the entire Goal.

Print Service Report: 

No services added.

[Add](#)

**Self-Directed Services**

No services added.

[Add](#)

### Goods and Services/Unpaid Caregiver Training

Must add at least one Fiscal Employer Agent - PPL service in the above section before adding a Goods and Services/Unpaid Caregiver Training service.

No PPL services added.

[Add](#)

## INSTRUCTIONS:

- All Waiver Services must be prior-authorized by the Division.
- The Services Authorization section must be completed with the waiver services requested for the IPC year.
- For services that are delivered in the traditional way, only certified Providers can be chosen from the drop down menu under “Services” tab. If you do not see a Provider in the drop down menu, this is because the Provider is not certified to provide that service. Contact the Provider if you feel this is an error.
- If a Participant is self-directing services, the Employer of Record will ensure the Provider meets the qualifications to provide the service and adds the service under the “Self-Directed Services” tab.

## IBA Section

1. Use the current IBA to determine how to utilize services on the IPC. You are required to stay within the allotted IBA amount. If not known, the IBAs are listed under Waiver Links under the “Individual Budget Amount” link.
2. If the IBA is not accurate, contact your Participant Support Specialist. You may be asked to provide documentation verifying if a different IBA had been approved by the Developmental Disabilities Section.
3. Double check the total IBA cost at the top of the page to ensure you have not exceeded the IBA amount. If you have gone over the allotted amount, the amount will be in parenthesis (\$42,000). If you are over the allotted IBA, you must keep adjusting the services to get back to the allotted amount or you must submit an IBA adjustment request. You will also see under the “Plan Status” link in red print “Plan is over the IBA”.
4. If the team determines that a Participant needs an IBA adjustment, you may submit an [Individual Budget Amount \(IBA\) Adjustment Request](#). This form is uploaded in the “Document Library” under Waiver Links along with any other documentation that will support the reason for the adjustment (refer to [IBA Adjustment and revised ECC Policy and Procedures](#) for details.)
  - a. Your request for additional services must be made 40 days in advance of the proposed IPC start date for services.
  - b. **After you upload an IBA Adjustment request and any supporting documentation, notify your PSS via email or by phone;** otherwise, they will not know to look in the “Document Library” for your request. **Include a description of the request in the “Notes” link under Waiver Links.**

- c. If a **request is for a required Subsequent Assessment, Support Brokerage services, or Agency with Choice services, a request form is not required**; however, provide a description why you are asking for these services in the “Notes” link under Waiver Links and let your PSS know via email or phone that you have added the notes.
- d. Only completed requests are reviewed by the Participant Support Specialist. The Participant Support Specialist will work with you to determine the information needed to complete the request and verify the need for the additional funding.
- e. If a child will age out of the Child DD Waiver during the plan year, the IBA and units must be calculated to reflect the correct number of days in service up to the end of the month of his/her 21st birthday.

## Services Section

For services delivered in the traditional way:

1. You will assure that all information is accurate and complete and enter the services in this section.
2. Upload all supporting documentation for services where documentation is required. **This includes:** Day or Residential Habilitation Intervention, Dietician Services, Individually Directed Goods and Services, Occupational Therapy, Physical Therapy, Skilled Nursing, Speech Therapy, Specialized Equipment, Subsequent Assessment, and Unpaid Caregiver Training.
3. **List the overall goal for each waiver service during the IPC year.** This goal needs to align with the Participant’s desired accomplishments for the IPC year that were documented in the “Individual Preferences” link.

NOTE: In the team meeting, the Participant must identify a long-term goal for the future. The goal is a brief clear statement of an outcome the Participant wants to achieve. It may be broad, general, tangible, and a descriptive statement. It does not say how to do something but rather what the results will look like.

## Self-Directed Services Section

1. If a Participant is self-directing, add the self-directed services in the Self-Directed Services tab on the Service Authorization link.
2. Enter and save the amount proposed to self-direct through the Fiscal Employer Agent or the Agency with Choice. This ensures self-directed money is listed so you can determine if the Participant is within his/her IBA.
3. If using PPL, your Participant Support Specialist will enter the self-directed amount in the PPL Web portal.

4. [Goods and Services](#) and [Unpaid Caregiver Training](#) require prior authorization by the Division. Refer to the [Request Goods & Services through Self-Direction: Step by Step Instructions](#).
5. If no traditional services are being modified, you will still need to open a modification and upload the Goods and Services/Unpaid Caregiver request then submit the modification. This will alert the PSS they have a pending task.
6. For information regarding [Support Brokerage](#), the Division website has forms and documents to assist you.

## Verification [BACK TO INDEX](#) [VERIFICATION USER GUIDE](#)

### PURPOSE:

1. Complete and upload Participant and Guardian Verification form
2. Address any conflicts of interest
3. Complete and upload Relative Disclosure form
4. Complete and upload Team Signature and Verification form

Enrollment: 7/1/2011 - 6/30/2012 (Active) IBA: \$100,846.00

Print:

### Verification

**Participant/Guardian Verification**

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

[Browse...](#)

**Relative Disclosure**

☐ A provider on the plan is related to the participant.

**Team Signature and Verification**

Please upload a Team Signature Verification form. You can download a copy of the form [here](#).

[Browse...](#)

[Save](#)

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### INSTRUCTIONS:

#### Participant/Guardian Verification

- The Participant, or Guardian if applicable, and you need to address the conflict of interest statement on this screen.
- The following are regarded as conflict of interest:
  - a. The Participant has chosen a self-employed Case Manager who also provides other services on the Participant's IPC (or)
  - b. The Participant has chosen a Case Manager employed by an organization that is also providing other services on the Participant's IPC.
- If one of the above applies, you check "This applies to me" on this screen.

- If there is a conflict of interest, you must work with the team and provide specific information in the box that opens after you click “This applies to me” documenting how you will address the conflict of interest.
- Questions to address a conflict of interest include:
  - a. How will you assure the development of the IPC is in the best interest of the Participant?

**Examples:**

- i. “My Case Manager meets with me and my Guardian to discuss ideas for the IPC and seek my input at the team meeting and during home visits. My Case Manager makes sure all Providers and my Guardian are aware of the potential conflict of interest and the IPC is developed as a team with input from everyone, including me and my Guardian. If I, my Guardian, or any other team member believes the Case Manager is not developing the IPC in my best interest, then a team meeting is scheduled and the team discusses the concerns. ”
  - ii. “My Case Manager has listened to me when I discussed my needs and personal goals and has helped me to plan services and choose Providers that will meet my needs. My Case Manager has ensured that my services are met best by a variety of Providers.”
- b. How will you assure monitoring of the implementation of the IPC is in the best interest of the Participant?

**Examples:**

- i. “My Case Manager monitors Provider documentation and incident reports. During Home visits, my Case Manager asks me about my services and if I have any concerns he/she should follow-up on. My Case Manager also told me to talk to \_\_\_\_\_ if I have concerns with my Case Manager or respite services and explained to me how to file a grievance with if I need to.”
  - ii. “My Case Manager asks my mom to look at the units provided by all Providers on my IPC. If my mom has questions, the Case Manager works with me and \_\_\_\_\_ to resolve the concerns.”
- c. How will you assure choice of Providers?

**Examples:**

- i. “My Case Manager explains that I have the right to choose from among different Providers. He/she assists, at my request, in contacting other Providers. My Case Manager reviews the Provider list with me at least twice a year or when I have a concern, complaint, desire or need to change Providers.”
- ii. “My Case Manager has helped me contact my local Participant Support Specialist and I know I can contact that person if I have questions or concerns.”

- Participant, or Guardian if applicable, must complete the [Verification form](#) and answer yes or no to the questions. This form must be printed, signed, scanned, and uploaded in this link.
- **The Verification form verifies:**
  - a. The Participant and/or Guardian have been an active part of the IPC development and acknowledge their responsibilities as a waiver Participant.
  - b. The Participant’s restrictions in the rights and restoration plan have been explained, along with his/her responsibilities.
  - c. The Participant and/or Guardian agree or disagree with the rights restrictions and restoration plan. Include his/her comments if there is a disagreement in the comments section on the Verification form.
  - d. The Participant and/or Guardian have reviewed his/her choices in Providers and waiver services available. Also Participant knows that he/she has a choice between home and community based services and the Wyoming Life Resource Center.
  - e. The Participant and/or Guardian have been informed of his/her right to a Fair Hearing.

### Relative Disclosure

- If a relative is a Provider on the Participant’s IPC, you will check this box. A section will open for the [Relative Disclosure](#) form to be completed and upload.
- This **form must be signed by a Division Provider Support staff.**
- This form will remain current as long as the Provider continues to provide services for that Participant. This form must be uploaded yearly with the IPC, but it does not require signing again. More details about the [HEA91 Relative Provider Information](#).

### Team Signatures and Verification

- After the IPC is fully developed, all team members are required to read and sign the [Team Signature and Verification](#) form and upload under the “Team Signatures and Verification” tab.
- If a team member’s signature is unable to be obtained due to an extraordinary situation, then you can work with your Participant Support Specialist on a timeline for submitting the signature.
  - a. Absent signatures result in the IPC being “incomplete” and are considered a certification issue for the Provider who failed to sign it.
  - b. You are required to include a “Note” under Waiver Link that a [Non Compliance](#) form has been submitted to a Provider Support Specialist and let your PSS know via email or phone that you have submitted a Non Compliance form and included a note.

- Providers who fail to sign the Team Signatures and Verification form will not be authorized to provide services on the IPC.
- In the event a Provider is not physically present at the team meeting, or when Providers are added or removed from an IPC, or just had their units changed with a modification to the IPC; it is the Provider's responsibility to verify their knowledge of the Verification form in writing, by fax, or email to you.
  - a. You must notify the Provider of what you expect in terms of a reasonable timeline to obtain their signature on the Verification form.
  - b. You then upload the written notification of their acknowledgement of the Verification form needing to be signed in the "Document Library" under Waiver Links.
  - c. Let your Participant Support Specialist know via email or by phone that you have uploaded this document.
- IPC is subject to approval by the Division. If changes are made in the approval process, you must notify all team members.
- **The IPC is distributed to team members after the IPC is approved by the Division. Services will not be provided until the modification is approved by the Division.**
  - a. Only team members who provide a direct care service will receive a copy of the IPC along with copies of any protocols developed or prescribed by a medical professional.

Team members are to receive a Service Verification form that does not include PA numbers on it – print the IPC in the EMWS without PA numbers.

**NOTE: Protocols do not automatically print when you click the icon to "Print IPC".** Therefore, you may want to print the protocols individually and attach them to the IPC that you distribute to the team members.
  - b. Such as protocols for mealtime, seizure, hygiene, Positive Behavior Support Plan, or other specific protocols.
  - c. Copies of Psychological Evaluations, Neuro-Psychological Evaluations, Medical Records, and Therapist Notes will not be attached to the IPC and are not to be distributed to the team.
- Providers are responsible for notifying you and the Division's Provider Support Specialist if a phone number, address, etc. changed during the year.
- **It is imperative this information is kept updated in IMPROV** as the Division used IMPROV email addresses to send out important listserv notices and keep information updated in the EMWS.

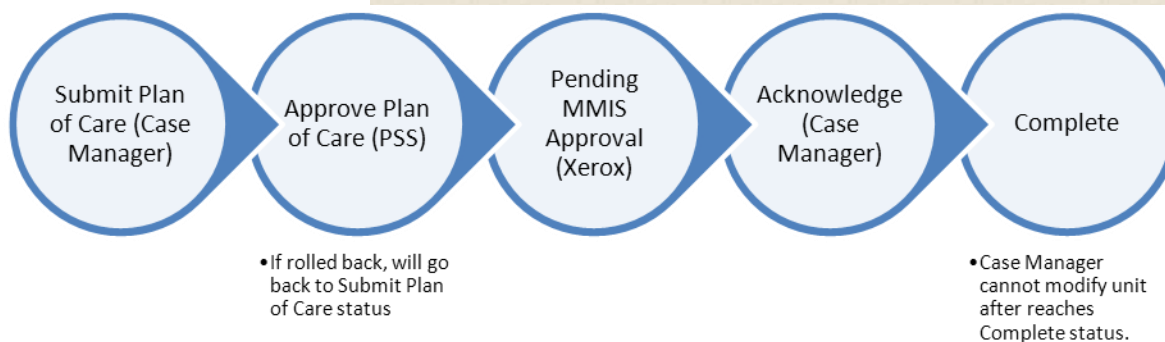
## Finalize IPC [BACK TO INDEX](#) [FINALIZE IPC USER GUIDE](#)

After you have completed all the steps in the IPC, you are ready to submit the IPC to your PSS for review and approval. Refer to CM Task [Timelines](#), [Task Clean-Up](#), and [Closure](#) for more details.

The screenshot shows the Medicaid Waiver System interface. The top navigation bar includes 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. The main header displays 'Waiver: DDD - Child', 'Participant: McNichols, George', and 'Case Manager: Aiken, Kirsten'. The left sidebar contains 'Waiver Links' and 'Plan of Care Links'. The main content area shows the 'History' tab with a table of process history. The first entry is 'Submit Plan Of Care' with a status of 'Submit Plan Of Care' (indicated by a green arrow icon). The 'Action' section shows a dropdown menu set to 'Submit to Participant Support Specialist' and a 'Complete' button. The 'Links' section includes a link to 'Planning Workbook for Individualized Plans of Care'.

Status	Description	Modified By	Modified Date
Submit Plan Of Care	Submit Plan Of Care		

### IPC Approval Process



**NOTE:** Once you see “Approve Plan of Care” under the Description in the History tab, you cannot make any changes. You can make changes when the status says “Submit Plan of Care”.

All Providers must verify annually they have been trained on the IPC and all health and safety protocols to keep the Participant safe.

This verification must be kept in the Provider's records and be available upon request by a PSS for review and the [Participant Specific Training](#) form is a helpful tool to document the training.

You are responsible for ensuring the training has taken place. In some cases, the training may be required by a medical professional or family member. Organizations can provide training to their employees once the designated trainer has been trained by you.

## Modifications to IPC

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[MODIFICATIONS IPC USER GUIDE](#)

- Modifications can only be made to the most current completed IPC. (For example; if the status of the IPC is “pending MMIS approval”, it cannot be modified.)
- You will be prompted to document a reason for the modification; if this is not completed, the modification will not be reviewed.
- Modifications to end the IPC must be submitted when the Participant moves out-of-state, passes away, or quits the waiver.
  - a. Ending the IPC must occur within 45 days of the event.
  - b. If Participant or guardian is no longer available to sign, note it on Team Signature Verification form.
  - c. You will use the “Close Case” in the EMWS under “Waiver” link to close the IPC. Refer to the [Closure User Guide](#) instructions for more details.
- **“Modification Effective Date”** must be completed on the “Plan Status” page. This date is seven days after the submission of a modification.
- **“Service Authorization” link is where modifications are submitted.** Make changes to the services in this link, upload any required documents (refer to Service Requirements for specifics), and then upload a signed copy of the [Team Signature and Verification](#) form.
  - a. Signatures must include all Providers whose rates/units are being changed.
  - b. You must submit in the “Documents Library” under Waiver Links the written verification from the Provider acknowledging the change in units. This can be a written note, an email, or fax that is scanned from the Provider affected by the change and uploaded.
  - c. In extraordinary situations, work with the Participant Support Specialist if signatures on the Team Signature and Verification form cannot be obtained from the necessary parties.
- **Added services to the IPC in the “Service Authorization” link must have the same start date listed on the “Plan Status” page.**
- The Division has seven days to process a modification from the date that a complete and accurate packet is received. The PSS has the ability to change the modification date if the submitted information is incomplete.
  - a. If an exception is necessary, submit your request in the “Notes” link under Waiver Links followed by a phone call or email notification to your Participant Support Specialist to let him/her know you have added notes.
- The [Transition Policy & Procedure](#) must be followed and the [Transition Checklist](#) submitted if the modification is a change in case manager, residential placement, or day services. Upload the checklist in the “Document Library”.

- **Once you submit a modification or IPC, it will roll over to the PSS task list.**

- a. Modifications made for a complete current plan are required to be submitted when there is a change in traditionally provided services, service rates, service units, Providers, self-direction dollars or units, or IPC start date. You can click the “Search Cases” tab at the top of the screen to locate the Participant needing a modification.
- b. An explanation for the modification is submitted in the “Notes” link under Waiver Links followed by a phone call or email notification to your Participant Support Specialist to let him/her know you have added notes. The

modification cannot be submitted without the reasoning for it.

- c. “Plan Start Date” must be completed in the space provided at top of the “Individual Preferences” link under Plan of Care Links for each modification. This is equivalent to the modification effective date. **All new service lines must have the same date.** Then a modification to an existing plan will be listed in the “Plans of Care” link located under Waiver Links with that IPC start date.
  - i. NOTE: PSS can change start date or service lines date if the modification is not approved by suggested IPC start date.

## Chapter 3 – Objectives & Schedules

### Overview [BACK TO INDEX](#)

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Objectives and Schedules are completed by the Provider and submitted to the Case Manager at least annually or more frequently as changes are needed, prior to the submission of the IPC to the Division for approval.

#### S.M.A.R.T.

Objectives are a specific, measurable, attainable, relevant, time specific and trackable conditions or skills that must be mastered in order to accomplish a particular goal.

- Objectives define the actions, which must be taken within a year to reach the goal.
- A goal is where you want to be and the objectives are the steps you have to take to reach the goal. What will success look like when the Participant has obtained his goal? Create a visual of the outcome in your objective.

#### Derived

Objectives are derived from the following:

- Information documented on long-term goals and areas of interest under the “**Individual Preferences**” section
- Discussions with Participant’s and his/her team about Participant’s long-term goals
- Health and safety concerns that are barriers for Participant in achieving his/her goals
- Ideas from Participant, family, or team member about how Participant may become more independent or make progress towards larger life goals
- Reviewing progress or status on past objectives then identifying the next achievable objective for the Participant

#### Content

Objectives must not be too lengthy or contain too many things to achieve. They must also be written in first person.

#### Medicaid Rules

As specified in the Medicaid rules; objectives must define the training activities for the Participant, the methods that will be used to train the activities, must be measurable and meaningful to the Participant, and must be reflected on the Participant’s personal schedule.

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## Habilitation

### Objectives

Habilitation services assist with the acquisition, retention, or improvement in skills related to living in the community. Therefore, **habilitation services require objectives.**

If a training objective cannot be implemented as part of a billable time period of habilitation service, the reason must be documented on the schedule or task analysis. (A task analysis can be a form made by Provider to track the Participant's objectives and it must meet Documentation Standards as defined by Chapter 45 in rule). Services requiring objectives include:

Residential Habilitation

Supported Living

Day Habilitation

Group Supported Employment

Community Integrated Employment

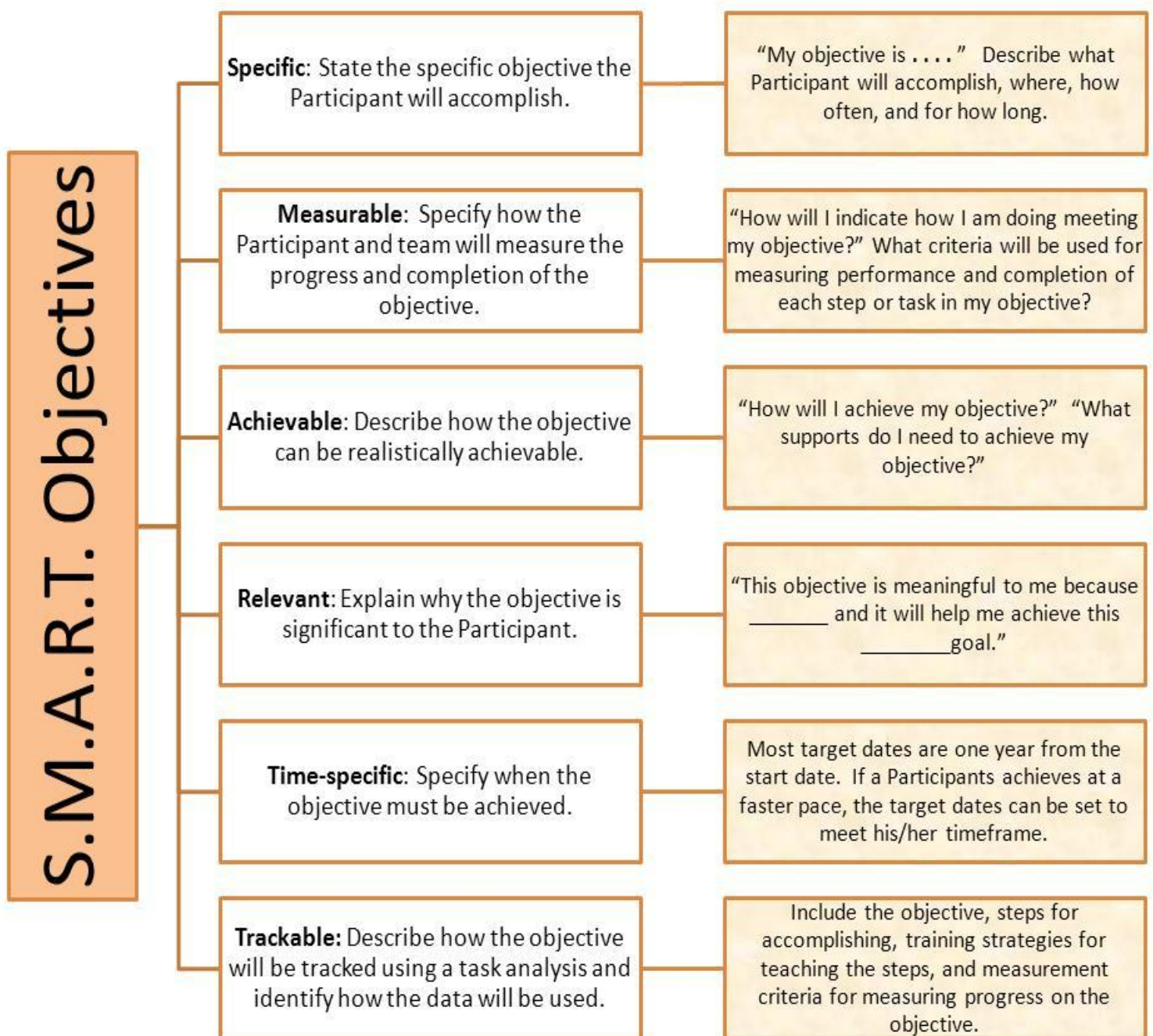
Special Family Habilitation Home

Residential Habilitation Training

Child habilitation

- 
- The Provider of the service on the objective form is responsible for writing the objective and developing the schedule for the service. You or other team members may assist the Provider in developing the objective and schedule, if needed or requested.
  - All sections on the objective page must be completed, including:
    - **Correct code**
    - **Start date** (corresponding with plan date)
    - **Review date** (monthly, quarterly, or semi-annually)
    - **Number of units** (If the team requests less than 350 days of Residential Habilitation and/or less than 230 days for day services, a statement is required why services are not needed throughout the year.)
    - **Provider responsible** (If more than one Provider is listed, then a person must be identified who will monitor for progress, consistency and continuity of services.)

- **Best Practice – write S.M.A.R.T. Objectives**



- **If this objective is continued from the previous IPC, indicate progress made by:**
    - a. Briefly summarizing last year’s progress on objectives in measurable terms.
    - b. Note areas of significant strength and/or weakness regarding the objective.
- 
- **“Methodology” defines how the objective is trackable.** It must contain specific action steps to accomplish the objective using the following:
    - a. Describe training activities or steps the Participant will practice. Specify strategies for Providers to teach, demonstrate, and observe steps of the objective.
    - b. Steps or tasks must be detailed according to the Participant’s level of ability and understanding.
    - c. Include the level of assistance Providers will use to train; such as gestures, positive reinforcement, hand-over-hand, role-playing, verbal prompting, pictures, etc.)
    - d. Document the ways it can be practiced, environments in which it can be done, and parties involved, if it can vary.
    - e. Information from the “Trackable” requirement as explained previously.
- 
- **Documentation and evaluation requirements:**
    - a. The objective and steps of the objective must be included in a task analysis on the schedule or on a separate form.
    - b. You must receive monthly documentation from the Provider(s), including progress on the objective, by the 10<sup>th</sup> business day of the next calendar month, per Medicaid rules noted in Chapter 45.
    - c. If a Case Manager is not monitoring correctly the Providers are meeting the Documentation Standards, the Case Manager may receive a Quality Improvement Plan.
    - d. For all services under Self-Direction, Case Managers are still required to monitor services.



More details about **Documentation Standards** available online at [BHD - DD Training](#)

- **You are responsible for assuring:**
  - a. If more than one Provider is listed, then a person must be identified who will monitor for progress, consistency and continuity of services.
  - b. If the objective page is used by more than one Provider, there must be an easy identification to see which Provider is responsible for the form and its implementation (important for auditing and billing review).
  - c. **If objective has been the same for a year or more and the Participant is not achieving success, then the following options will be given:**
    - a. Objective may be revised to try new methodologies, new strategies and activities, be more specific, or
    - b. Objective may be changed completely, or
    - c. You are advised to either:
      - i. Add the objective or goal to the schedule to record on-going training in this area
      - ii. Include this unachieved objective in the pertinent areas of the IPC where supports and supervision are described
- For families who are utilizing self-direction for habilitation services, **the Employer of Record and you must ensure all progress on objectives is recorded on the time sheet through PPL.**



More details about **Objectives and Schedules** available online at [BHD - DD Training](#)

## Schedules [BACK TO INDEX](#)

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- Schedules must be developed and completed for day & residential habilitation services, respite, personal care, companion, and homemaker services.
- **Schedules must be:**
  - a. A personalized list of tasks or activities that describe a typical week for a Participant.
  - b. Individualized and reflect the wants and desires of the Participant as listed in “Individual Preferences”
- **Schedule must include:**
  1. Name of Participant
  2. Service Code or Description
  3. Plan Date
  4. Location of Service
  5. Name of service being provided
  6. Approximate number of hours in service (per day/week/month)
  7. Details on training on specific objectives for habilitation services (if methodology for objective is on the schedule instead of a separate objective page)
  8. A brief description of support needed as specified in the IPC (staffing ratios do not have to be included)
  9. Personal care needs during the time of service, if applicable
  10. Health and safety needs
  11. Positive Behavior Support Plan components, as applicable including: targeted and replacement behaviors, use of PRNs, restraints and restrictions. (Providers do not need to keep track of this data twice; for example tracking in both Schedules and the PBSP. They can keep track of it in one place but need to have the tracking available for the PSS if they ask to review it.)
  12. Participant’s choice of activities
  13. Community outings (Provider fill in specific location when documenting on the schedule)
  14. Date (month, date, year)

15. Time in and time out for provision of services
  16. Choose AM/PM or military time
  17. Staff needs to identify time consistently on the schedule and not switch between AM/PM and military time
  18. More than one box for “time in/time out” must be available, if the Participant leaves the service more than once a day for therapies, other waiver services, school, etc.
  19. Place for each staff member of each Provider to initial when tasks have been completed (Initials must match full signature)
  20. Place for full signature for each staff member of each provider (per physical page)
  21. Notes/Comments section (if completed, include date of comment)
- **Schedule for Intervention must include:**
    1. Name of Participant
    2. Service Code and Service Description
    3. Plan Date
    4. Location of Service
    5. Type of Intervention being provided
    6. Approximate number of intervention hours (per day, week, or month)
    7. Details for staff on how to intervene with the Participant to address the specific behavior, medical need, personal care, or other usage.
    8. A description of the level of support needed for specific activities, such as total assistance, hand over hand, etc.
    9. Personal care needs during the time of service, if applicable
    10. Health and safety needs
    11. Behavior plan components, if applicable
  - Social Security Numbers and Medicaid ID numbers on the schedule are discouraged. Due to HIPAA concerns, if schedules were taken into the community, the identification numbers would not be safe to have on the schedule.
  - The schedule verifies services were delivered for billing purposes. Therefore,
    - a. It must be developed with all of the above components, and
    - b. Filled out, initialed, and signed by staff accurately, or
    - c. The provider may have to pay back money for services if standards are not followed

- Providers must adhere to the documentation and reporting standards in rule and may develop individualized format. There are examples in the Documentation Standards [BHD - DD Training](#).
- Each Provider is responsible for developing, updating, and distributing the approved schedule for their service to all staff or team members who deliver the service, as well as giving a copy to the Case Manager.
- If the Provider needs assistance with developing the schedule, the Case Manager should assist the Provider as needed.
- The completed schedule must be submitted to the Case Manager by the 10<sup>th</sup> business day of following month, along with billing documentation.



More details about **Objectives and Schedules** available online at [BHD - DD Training](#)

## Chapter 4 – Service Requirements

### Agency with Choice (Self-Directed Services only) [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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#### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **How will you accomplish a quality assurance program that includes measurements of Participant satisfaction?**

### Case Management [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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#### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service
  - a. **Goals for traditional case management must include the following explanations:**
    - How will you assure the Participant's IPC is person-centered?
    - How will you accomplish reviewing Provider documents to ensure they meet Documentation Standards, are submitted by the 10<sup>th</sup> business day of each month following services, and services are billed correctly?
  - b. **Goals for self-directed case management must include the following explanations:**
    - How will you accomplish monitoring the IPC, including self-directed and traditional services?
    - How will you accomplish reviewing services to ensure amount, frequency, and duration of services are appropriate?
    - How will you accomplish documentation of all services is provided monthly?

## Child Habilitation (Child DD waiver only) [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
  - a. The rate for children through ages 12 does not include the basic cost of childcare unrelated to a child's disability that may be needed by parents or regular caregivers. It is the responsibility of the Provider to collect the basic cost of child care from the parent or caregiver.
  - b. NOTE: When a child turns 13, you must change the code from T2026 to T2027; otherwise, you will not be paid.
3. Enter your goal for this service, explain:
  - a. **What will the Participant be able to do at the end of the year that he/she cannot do now as a result of this service?**
    - This may include goals in training, coordinating and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management.

### REMINDERS

- Providers are responsible for submitting objectives and schedules for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date. These must include all the necessary requirements as explained above.

## Cognitive Retraining (ABI waiver only) [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- There is no schedule required for Cognitive Retraining service but you could develop one.
- The professional must document what occurred during each session and turn it into you by the 10<sup>th</sup> business day of the following month.

## Community Integrated Employment

[BACK TO INDEX](#)

[SERVICE DEFINITION](#)

### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- Providers are responsible for submitting objectives and schedules for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.
- You are required to have documentation in the Participant's file that employment was discussed in the Participant's Individualized Education Plan (IEP). The team and all Providers acknowledge that Community Integrated Employment cannot be used during normal school hours for Participant's ages 18 through 20.
- Teams must explore if the Division of Vocational Rehabilitation or the local school districts will pay for supported employment services.

#### 1. Division of Vocational Rehabilitation (DVR) will not pay if:

- ✓ The job is in a non-integrated environment, where more than half of the employees do have disabilities (such as facility-based work), or
- ✓ The Participant *does not want* community-based, integrated employment.
- ✓ If a Participant has a community job or wants to pursue community employment, complete the questions in the plan concerning DVR.
- ✓ The Participant should contact DVR to verify that his/her desired employment would or would not qualify for DVR services.
- ✓ Participants, who are not able to access services without assistance, may have the guardian or you contact DVR on his/her behalf to set up an appointment. If a Participant has another person assist with contacting DVR, then a Release of Information from DVR to the 3<sup>rd</sup> party is required from the Participant or Guardian, if there is one.
  - a. DVR may be able to assist the person with supported employment services, but the Participant, and 3<sup>rd</sup> party if necessary, must attend appointments consistently to ensure successful employment outcomes.

**2. Waiver may pay if:**

- ✓ DVR closes the case and the Participant still requires supported employment to maintain the current employment position.
- ✓ The job is located in the community or in a business that is part of a Provider organization, such as an enclave, where the Participant is paid at or above minimum wage.
- ✓ The need for supported employment is justified in the IPC and the Participant's budget will allow for the units requested.

**3. Waiver will not pay if:**

- ✓ Supported employment services can be provided by DVR.
- ✓ The Participant is making below minimum wage. If the Participant receives reimbursement for habilitation objectives during day habilitation services, then a fair and equitable wage is determined by the Provider for the tasks performed.
- ✓ Services are for transportation assistance only and no habilitation is needed.
- ✓ Reimbursement is for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize employer's participation in a supported employment program.
- ✓ Payments are passed through to beneficiaries of supported employment programs, or
- ✓ Payments are for vocational training not directly related to a supported employment program.

## Companion Services

[BACK TO INDEX](#) [SERVICE DEFINITION](#)

### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- A variety of activities to increase independence and quality of life will be provided during this service. There is NO requirement for a formal objective. However, a schedule must be developed and turned into you by the 10<sup>th</sup> business day of the month following services and prior to the IPC start date.
- A provision of Companion Services does not entail hands-on nursing care; it does include Personal Care assistance with activities of daily living as needed during the provision of services.  
**NOTE:** Personal Care and Companion cannot be on the same IPC.

- Companion Service is a 15-minute unit and is available as a 1:1 service or a group rate. With the group rate, Providers can provide Companion Services for up to three participants at the same time.
- This service is available to Participants ages 18 and up. Companion Services provided to Participants ages 18 through 21 may not duplicate or replace services that are covered under Individuals with Disabilities Education Act (IDEA) and cannot be provided during school hours.

## Day/Residential Habilitation & Intervention [BACK TO INDEX](#)

[SERVICE DEFINITION DAY HABILITATION](#)

[SERVICE DEFINITION RESIDENTIAL HABILITATION](#)

### Complete the following in EMWS:

1. Select the correct supervision service code
2. Select the service Provider from the drop down menu
3. Enter units allocated
4. Enter your goal for this service, explain:
  - a. **How are individual preferences supported by this service?**
5. Click Browse and upload the file if the service is Day Habilitation “Intervention” or upload the file if the service is Residential Habilitation “Intervention”

### REMINDERS

- Refer to the Objectives and Schedule sections of the IPC Instructions for completing the necessary requirements. Refer to Service Definition links above for more information.
- Providers are responsible for submitting objectives and schedules for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.

### Intervention Units

- Intervention units can be used for situations where a Participant’s standard supervision level may not provide sufficient staffing for specific activities or events included in the IPC, but the supervision level is not needed at all times. Eligible situations for intervention are on [Figure A-1](#).
  - a. The intervention option must be used to request additional staff, when needed, to provide intensive 1:1 support for the Participant, because the assigned setting is not adequate to meet specified health and safety needs.
- It is expected that a Participant will receive 1:1 support at times specified in the IPC for assistance with ADLs and for objective training, regardless of the supervision level.
- If intervention units were approved by the Division on the last plan, those units will be approved on the new IPC as long as the IPC continues to support that level of supervision. You do NOT need to submit a new “Supervision Level and/or Intervention Request”.
- If the Participant requires additional intervention units than were approved on the previous IPC, then a [“Supervision Level and/or Intervention Request”](#) form must be submitted and the IPC information must support the supervision level requested.
  - a. If the request for additional intervention exceeds the IBA, the Extraordinary Care Committee process will be followed. **Intervention requests are subject to approval by the Division.**
- Document the service (residential and/or day habilitation) where intervention will be used, how the additional staff for intervention is accessed, and what intervention will be utilized then upload the file.
- Schedules must include:
  - a. A personalized list of daily living activities, behaviors or tasks that need exclusive staff support and supervision
  - b. Addressing the specific areas of concern in the areas of health and safety
  - c. Be developed by the Provider who will do the intervention with the Participant
  - d. Refer to the [Schedules](#) for more details on what to include regarding intervention.

## Environmental Modification [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- Refer to [Chapter 44](#) Medicaid Rules for specific details regarding Environmental Modifications.
- Summarize the request in writing and upload the document using the [File Naming Convention](#) in “Document Library” under Waiver Links. You can use the [Environmental Modifications](#) form developed by the Division.
- Call your PSS prior to getting bids to see if the request can be approved by the Division. Approvals **must meet at least two of the following criteria**:
  - i. Be functionally necessary, and
  - ii. Contribute to a person’s ability to remain in or return to his or her home and out of an ICF/ID setting, or
  - iii. Be necessary to ensure the person’s health, welfare, and safety.
- After the request is submitted, the Division may:
  - a. Schedule an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate professionals under contract with the Division, or
  - b. Instruct you to proceed, or
  - c. Deny the request
- If the request is approved, you will enter the goal explaining how this modification will benefit the Participant and upload the following using the [File Naming Convention](#):
  - a. Photos or drawings
  - b. Two quotes completed by certified environmental modification Providers, which must include:
    - i. A detailed description of the work to be completed, including drawings or pictures when appropriate.
    - ii. Estimate of material and labor needed to complete the job, including costs of clean up.
    - iii. Estimate for building permit, if needed.
    - iv. Estimated timeline for completing the job.
    - v. Name, address, and telephone number of the Provider.
      - If two quotes cannot be obtained, include documentation explaining why only one quote was submitted.

## Homemaker [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

1. Providers are responsible for submitting a schedule for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.
2. This service does not include supervision.

## Individually Directed Goods and Services [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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*\*\*In order to take advantage of the opportunities under this service, the Participant must be self-directing at least one other direct care service through PPL.*

### Complete the following in EMWS:

1. Click “Add” under Goods & Services/Unpaid Caregiver Training in Self-Directed Services tab
2. Click the down arrow and select the type of service
3. Click “Browse” to upload the [Goods & Services](#) form
4. Upload in “Documents Library” under Waiver links any quotes, invoices, etc. needed to prior authorize the purchase of the Goods or Service, notify PSS via email or phone when documents have been uploaded
5. Click “Save”

### INSTRUCTIONS

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• This service could be used for:<ol style="list-style-type: none"><li>a. Specialized Equipment</li><li>b. Devices, aids, controls, supplies, or household appliances which enable Participants to increase their ability to perform daily activities</li><li>c. Transportation provided by family members (excluding parents, step-parents, guardians, or spouses per Wyoming State Statute), friends, and other licensed drivers, using non-agency vehicles to transport the person to and from services and</li></ol></li></ul> | <ul style="list-style-type: none"><li>activities as specified in the Participant’s IPC, unless the service includes transportation. The unit of service is one mile.</li><li>d. Home modifications - that do not meet the requirements of <a href="#">Chapter 44</a></li><li>e. Camps – Must identify how the service would provide direct benefit to the Participant and support and training of the plan of care</li><li>f. Consultation, evaluation and training, and/or a written document</li></ul> |
|--|--|

- **The limit is \$2000 per plan year unless the request addresses:**

- a. Unmet needs because of aging out of school
- b. Documented unavailability of vocational rehabilitation (DVR) services
- c. Increasing health concerns that require more services
- d. Increasing behavioral concerns that require more intervention
- e. Health needs of unpaid caregivers who cannot continue the historical level of support

**Follow this process:**

1. Participant or legal representative, operating as the Employer of Record, must check to see if the “Goods or Service” meets the criteria in the service definition and the cost of the Goods or Service is within the \$2000 limit for the service for the plan year.
2. When the Employer of Record wants to purchase an item under Goods and Services, they must:
  - a. Discuss the Goods or Service needed with the Support Broker;
  - b. Decide together on a detailed plan, including the specific item(s), service, size, vendor, etc., which meets the service definition;
  - c. Gather information on the costs, bids, quotes, etc. with help from the Support Broker as needed; and
  - d. Gather the information you need to complete [Goods and Services](#) form.

3. After making a decision, you are notified by the Division.
  - a. If approved, PPL is notified via email by Division staff.
  - b. PPL confirms with an email back to Division Staff.
4. You then allocate money for the item in the PPL Web Portal.
5. The Employer of Record, with help from the Support Broker if needed, completes the PPL Requisition Invoice to PPL, which is available on the PPL website or by contacting their customer service line.
6. When the invoice is considered complete and approved by PPL, then PPL issues a check to the vendor listed on the requisition invoice during the next pay cycle for the Goods or service, and the check is sent to the Employer of Record.
  - a. If the vendor does not accept a check, the employer and/or you must contact PPL for assistance or an alternative solution.
7. You must make a copy of approved [Goods and Services](#) form and send it to the Employer of Record.
  - a. For “services”, the Employer of Record shows the vendor the approval on the form and sets up the time to start the service.
  - b. For “goods”, the vendor purchases the goods and ensures they are delivered or picked up by the employer.
8. The Employer of Record will decide when to pay the vendor for the Goods or Service.
9. The Employer of Record keeps the receipt for the Goods or Service and is responsible for ordering the equipment.
10. You must keep a copy of the receipt in your file too.

## Occupational, Physical, Speech Therapy & Dietician Services

[BACK TO INDEX](#)

[OCCUPATIONAL SERVICE DEFINITION](#)

[PHYSICAL THERAPY SERVICE DEFINITION](#)

[SPEECH THERAPY SERVICE DEFINITION](#)

[DIETICIAN SERVICE DEFINITION](#)

### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**
4. **Click Browse and upload the Physician's order**

### REMINDERS

- Occupational Therapy, Physical Therapy, and Speech Therapy have an individual rate and a group rate. The Participant may receive either individual, group, or both, and the Physician's order must reflect which service is appropriate for the Participant.
- There must be a recommendation from the therapist outlining the expected outcome of the therapy. It must be individualized to the Participant prior to therapy services.

## Personal Care

[BACK TO INDEX](#) [SERVICE DEFINITION](#)

*\*\*Personal care must be provided in the Participant's home or on their property and cannot include transportation.*

### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- Providers are responsible for submitting a schedule for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.
- Units must be based on Participant needs with a maximum of 7280 units of Personal Care in a plan year, unless more are approved by the Division due to extraordinary circumstances.
- Personal Care includes tasks that need to be accomplished for a Participant through hands-on assistance (actually performing a task for the Participant) or cuing/prompting the Participant to perform a task.
- Personal Care services may be provided on an episodic or on a continuing basis and do not require a teaching or training component.

- Personal Care can include Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
  - a. ADLs include bathing, dressing, toileting, transferring, positioning, maintaining continence, personal hygiene tasks, eating, etc.
  - b. IADLs include more complex life activities, such as light housework, laundry, meal preparation, exclusive of the cost of the meal, using the telephone, medication and money management.

## Residential Habilitation Training (Child DD waiver only) [BACK TO INDEX](#)

### [SERVICE DEFINITION](#)

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### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What will the Participant be able to do at the end of the year that he/she cannot do now as a result of this service?**
    - i. This may include goals in training, coordinating and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management.

### REMINDERS

- Refer to the Objectives and Schedule sections of the IPC Instructions for completing the necessary requirements.
- Providers are responsible for submitting objectives and schedules for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.

## Respite Care [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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*\*\*Respite is intended to give short-term relief for the primary caregiver and is not intended to be used when the primary caregiver is at work or during regular hours of the local school district if the participant is under 21.*

### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- Providers are responsible for submitting a schedule for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.
- A variety of activities to increase independence and quality of life will be provided during this service. There is NO requirement of a formal objective.
- On all Waivers, the cap is units per plan year if living with family - 7280 units and 2500 units if living in residential services with a non-CARF accredited Provider. Unit requests exceeding the cap must be requested using the [Individual Budget Amount \(IBA\) Adjustment Request](#) form.
- Respite can only be provided to two Participants at the same time unless a Participant's IPC requires 1:1 support. Providers cannot provide respite services to children and adults at the same time, unless approved in advance by the Division.
- You must acknowledge in this section that all Providers are aware that respite is not being provided:
  - a. during school hours
  - b. not when the caregiver is working
  - c. schedule meets all the documentation requirements as outlined in Medicaid Rule, [Chapter 45](#)

## Skilled Nursing [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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**\*\* Skilled Nursing services must be medically necessary for each Participant that requires a nurse and cannot be completed by Providers. Physician's orders need to be relevant to the Participant's diagnosis and needs.**

### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**
4. **Click Browse and upload the Physician's order for Skilled Nursing service, which must include preventative and rehabilitative procedures**
  - ✓ Physician's order requires Physician's signature, a stamp is not accepted
  - ✓ Physician should be fully involved in Participant's medical treatment plan
  - ✓ Physician must carefully review the Skilled Nursing services needed for the Participant BEFORE signing the order
  - ✓ Blank order signed by a Physician is not accepted – form must be completed by Physician
  - ✓ Physician's order valid for one year from the date signed by the Physician

### REMINDERS

- The services on the Physician's order must be reflected in the documentation of services delivered.

## Specialized Equipment [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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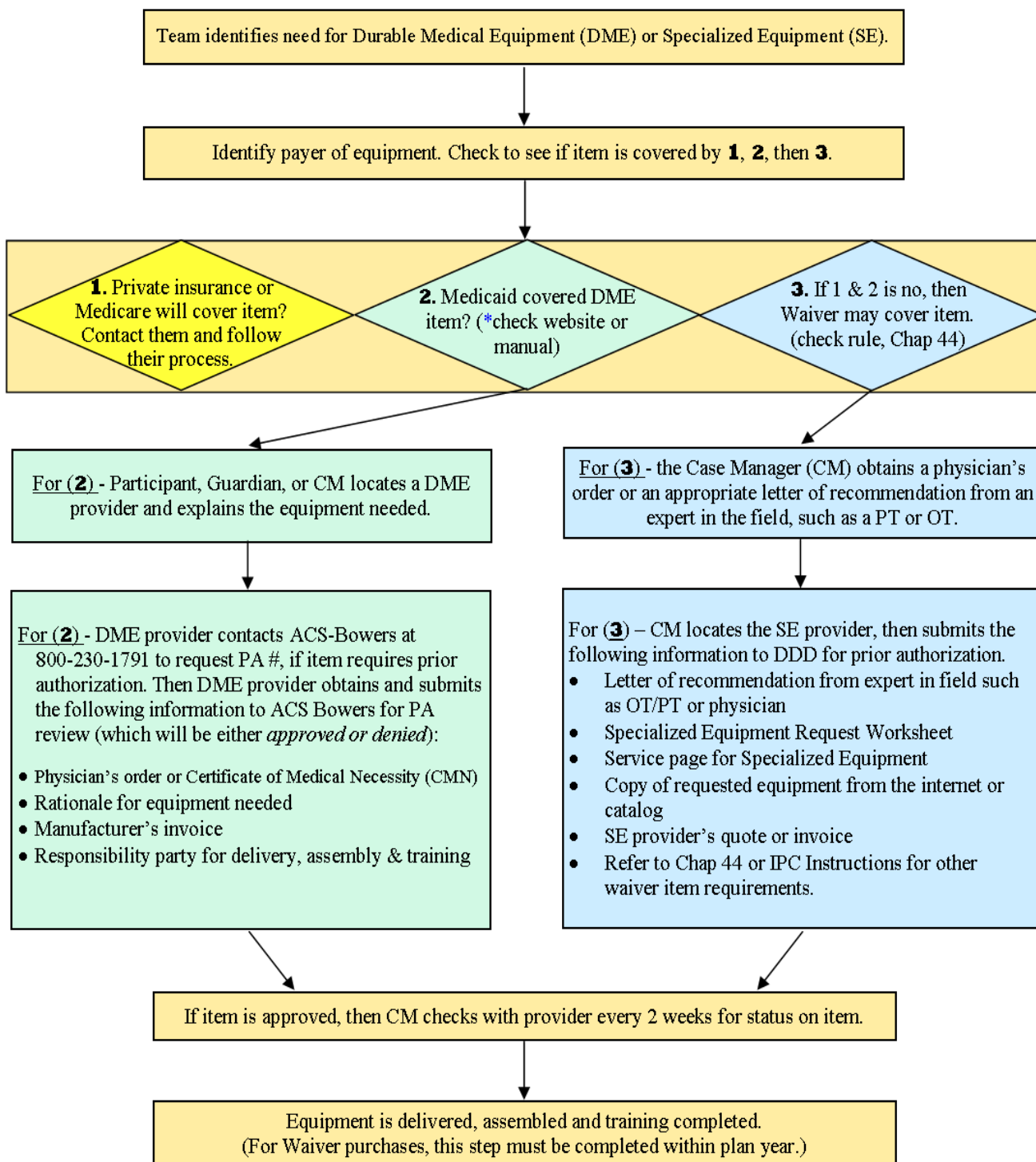
### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**
4. **Click Browse and upload a written recommendation from a licensed health care professional**

### REMINDERS

- Specialized Equipment shall meet at least 3 of the following criteria:
  1. be functionally necessary
  2. increase abilities to perform ADLs or communicate with the environment in which the Participant lives
  3. be necessary to enable the Participant to function with greater independence
  4. be necessary to ensure the Participant's health, welfare, and safety
- Refer to [Chapter 44](#) of Medicaid Rules for specific details regarding Specialized Equipment, including identifications of items not allowable.
- Requests for Specialized Equipment must be discussed at the annual meeting or the six-month review unless there are significant health and safety concerns requiring immediate discussion.
- Waivers will not purchase any equipment that would be authorized under a Medicaid state plan or under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
  - a. Refer to the [Flowchart for DME or Specialized Equipment](#) requests. This is a process for checking if the equipment is a Medicaid covered Durable Medical Equipment (DME) item; if not the process for requesting equipment through the waiver.
  - b. If the item(s) are not covered by Medicaid, continue on the right hand side of the Flowchart.
- [Specialized Equipment Service](#) worksheet is to assist teams in determining whether an item will meet the covered items in Chapter 44 of Medicaid rules.
- The Division may schedule a review of the Specialized Equipment quote, including an evaluation of functional necessity, with appropriate professionals under contract with the Division.
- For communication devices, you may contact WIND/WATR, University of Wyoming, for further assistance: 888-989-9463 or [watr@uwyo.edu](mailto:watr@uwyo.edu).
- A number of items that may not be approved through traditional services may potentially be approved/purchased through Self-Direction under Goods and Services.

# FLOWCHART FOR DME OR SPECIALIZED EQUIPMENT



\* <http://wyequalitycare.acs-inc.com/manuals/dme/>

## Subsequent Assessment [BACK TO INDEX](#)

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### Complete the following in EMWS:

1. Select the service Provider by clicking in the box, a list will appear
2. Enter the unit cost
  - a. Subsequent Assessment for a continued eligibility psychological or neuropsychological evaluation cannot exceed \$1,000 over the IBA.
3. Enter units allocated
4. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**
5. Enter proposed month
  - a. This is the month the assessment is expected to be completed during the plan year.
6. Enter reason for assessment
  - a. This can be more than continued eligibility. The purpose may be to give more detailed guidelines on working with the Participant.
7. Click Browse and upload the quote for the professional providing the assessment

### REMINDERS

- Subsequent Assessment must be pre-approved BEFORE the assessment is scheduled.
- If the completed assessment is a psychological assessment required for eligibility, you must go to the [“Assessment History”](#) link under Waiver Links in EMWS and to “Add” an Assessment.
- If the completed assessment is for other purposes, it must be uploaded in the [“Document Library”](#) under Waiver Links.
- If the psychological/neuropsychological expires within 6 months prior to the ICAP expiration date, the psych/neuropsych evaluation needs to be submitted prior to requesting the new ICAP assessment.
- Other assessments may be pre-approved by the Division. In most instances, the assessment will need to stay within the existing IBA. If necessary, an IBA Adjustment Form must be included.

## Supported Living Services [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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### Complete the following in EMWS:

1. Select the service Provider from the drop down menu
2. Enter units allocated
3. Enter your goal for this service, explain:
  - a. **What benefit will the Participant receive as a result of this service?**

### REMINDERS

- Supported Living services are services to assist Participants to live in their own home, family home, or rental unit. These individuals do not require ongoing 24-hour supervision, but do require a range of community-based support to maintain their independence. They require individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community.
- Supported Living services must be based upon need. These services can include:
  - a. assisting with common daily living activities
  - b. performing routine household activities to maintain a clean and safe home
  - c. assistance with health issues, medications, and medical services
  - d. teaching the use of the community's transportation system
  - e. teaching the use of police, fire and emergency assistance
  - f. managing personal financial affairs
  - g. building and maintaining interpersonal relationships
  - h. participating in community life
  - i. 24-hour emergency assistance
- This service includes Personal Care; therefore, Personal Care services cannot be added as a separate service on the IPC.
- Providers are responsible for submitting objectives and schedules for this service to you by the 10<sup>th</sup> business day of the month following service and prior to the IPC start date.
- Supported Living services can be a daily or 15-minute unit. The daily unit provides for at least seven hours of service, requires a minimum of 4-hours a day of services and can be reimbursed for up to three participants. The maximum of 15-minute units will be 5400 units in a plan year for the group rate and 3900 units for the individual rate.
- A Supported Living service is available to Participant's ages 18 and older. This service provided to Participants ages 18 through 21 may not be duplicated or replace services that are covered under Individuals with Disabilities Education Act (IDEA) and cannot be provided during school hours.

## Unpaid Caregiver Training [BACK TO INDEX](#) [SERVICE DEFINITION](#)

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\*\* Participant must be utilizing Public Partnerships, LLC (PPL).

### Complete the following in EMWS:

1. Click “Add” under Goods & Services/Unpaid Caregiver Training in Self-Directed Services tab
2. Click the down arrow and select the type of service
3. Click “Browse” to upload the “Unpaid Caregiver Training” form
4. Click “Save”

### REMINDERS

- The limit is \$2000 per plan year unless the training addresses critical health or welfare needs.
- This service cannot pay for costs of travel, meals, and overnight lodging.
- Once the request has been approved by the Division, PPL will be notified. Then they will notify you that the training can be scheduled.

## Chapter 5 – Forms & Helpful Tools

### IPC Required Forms [BACK TO INDEX](#)

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#### ***Guardianship Papers***

- Whenever there is a court appointed Guardian - guardianship papers must uploaded in “Contacts” under Waiver Links.
- For a child under 18 - his/her Parents are the legal Guardian unless an alternate person is appointed by a court.
- When a child turns 18 years of age, he/she is legally an adult and is responsible for signing all IPC documents unless there is a court order changing that status.
  1. The Division cannot accept guardianship papers that state “minor child”, if the participant is 18 or older, unless it meets the following criteria:
    - a. “A guardianship, initiated while the ward is a minor, does not lapse at the age of majority under Wyo. Stat.Ann.3-3-1101, if it is based on incompetency as defined in Wyo. Stat. Ann. 3-1-101(a)(ix) or (xii).”
  2. You are responsible for having the Participant sign the forms until the guardianship can be corrected.
- If there is a limited guardianship, assure that the dates are current and the document is uploaded in “Contacts” under Waiver Links.
- For a Child who is not living with Parents, if guardianship papers are not available, an explanation must be submitted.

#### **Habilitation Support Worksheet**

- Required to be uploaded under “Needs, Risks, and Restrictions” link in Habilitation Support Area. You and Division staff will use this document to monitor staffing patterns.

#### **ICAP Authorization Form**

- Complete the ICAP Authorization form, which requires Participant/Guardian signature documenting permission for WIND to interview respondents for ICAP renewals. Upload this ICAP Authorization form under the first respondent using the [File Naming Convention](#) under the “Assessment” link. Then click the “Action” button to submit the ICAP to your PSS for review.

**Medication Consent Form**

- Upload the Medication Consent form under the “Medical” link in the Medications tab area where it prompts you to upload medication documents. When adding medications, you will click the drop down menu to identify the level of assistance required.

**Team Signature and Verification Form**

- After the IPC is fully developed, all team members are required to read and sign the Team Signature and Verification form then upload in the Team Signature and Verification tab under the “Verifications” link.

**Verification Form**

- Participant, or Guardian if applicable, must complete the Verification form and answer yes or no to the questions. This form must be printed, signed, scanned, and uploaded in the Participant/Guardian Verification tab under the “Verification” link.

## IPC Helpful Forms/Worksheets/Samples [BACK TO INDEX](#)

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### **“About Me”** Worksheet

- This is a helpful tool to assist you and teams in completing the “Individual Preferences” section in the EMWS for a Participant’s IPC.

### **Environmental Modifications** Form

- Summarize your request in writing for an environmental modification and upload the document using the [File Naming Convention](#) in “Document Library” under Waiver Links. You can use the Environmental Modifications form developed by the Division.

### **Functional Assessment** Template Sample

- The team completes a PBSP based on a Functional Behavior Assessment. The Functional Assessment can be used to help guide the team thinking why the behavior might be here in the first place versus just restricting a Participant as a means to control his/her behavior.

### **Individual Budget Amount (IBA) Adjustment Request** Form

- If it is determined that a Participant needs an IBA adjustment, you may upload an IBA Adjustment Request form and all supporting documentation in the “Document Library” under Waiver Links.
- If the IBA Adjustment Request form is submitted with the IPC, it is to be submitted 40 calendar days before the intended IPC start date. This form and all supporting documentation are uploaded in the “Document Library”, using the [File Naming Convention](#).
- If you upload an IBA Adjustment Request form, alert your [Participant Support Specialist](#) (PSS) via phone or email of your additional funding request so they know you uploaded the form and can review it.
- You may also use the “Service Authorization” form to itemize the services, units, and costs for the IBA Adjustment Request.
- If the request is for a required Subsequent Assessment, Support Brokerage services, or Agency with Choice services, then the request form is not required. You must include what the request is for in “Notes” under Waiver Links.
- Only complete requests are reviewed by the Participant Support Specialist. The Participant Support Specialist will work with you to determine the information needed to complete the request and verify the need for the additional funding.

- The Participant Support Manager or Designee determines if the request is reviewed by the Extraordinary Care Committee (ECC). If so, the Participant Support Specialist will work with you to gather any additional information and schedule the ECC review.

### **Medication Assistance Record (MAR) Form**

- Some Case Managers are not entering all the medications, opting instead to complete the Medication Assistance Record (MAR) and upload this document under the “Medical” link. This allows Providers to have more specific information. A new MAR can be uploaded whenever there are medication changes.

### **“My Medical” Services Worksheet**

- You are responsible for assuring Participants obtain regular medical treatment, including immunizations, annual assessments, blood work, etc. You must keep a schedule of medical appointments. My Medical Services worksheet is available to assist you in this documentation and can be uploaded under the “Medical” link.

### **Non Compliance Form**

- If a team member’s signature is unable to be obtained due to an extraordinary situation, then you can work with your Participant Support Specialist on a timeline for submitting the signature.
  - Absent signatures result in the IPC being “incomplete” and are considered a certification issue for the Provider who failed to sign it.
  - You are required to include a “Note” under Waiver Link that a Non Compliance form has been submitted to a Provider Support Specialist and let your PSS know via email or phone that you have submitted a Non Compliance form and included a note.

### **Participant Specific Training Form**

- All Providers must verify annually they have been trained on the IPC and all health and safety protocols to keep the Participant safe. This verification must be kept in the Provider’s records and be available upon request by a PSS for review.
- You are responsible for ensuring the training has taken place. In some cases, the training may be required by a medical professional or family member. Organizations can provide training to their employees once the designated trainer has been trained by you.

### **Plan of Care Worksheet**

- The Plan of Care worksheet is the paper version of the electronic IPC and can be a helpful guide to assist you in completing the IPC.

### **Planning Workbook for IPC Workbook**

- This Planning Workbook is designed to help you complete the IPC encouraging a person-centered planning approach.

### **Positive Behavior Support Plan (PBSP) Template Sample**

- This template is a sample you can use to help guide you in building a PBSP. Other versions are acceptable provided the components of the IPC align with Chapter 45 of the Wyoming Medicaid Rules. The PBSP is uploaded under the “Behavioral Supports” link.

### **Relative Disclosure Form**

- If a relative is a Provider on the Participant’s IPC, you will check the box under the “Verification” link in the Relative Disclosure tab. A section will open for the Relative Disclosure form to be completed and upload.

### **Rights, Responsibilities and Restrictions Guide**

- You are required to apply the Rights, Responsibilities and Restrictions and to review this guide with the Participant and his/her Guardian every six months or as needed. This form is not uploaded in the EMWS.

### **Rights, Responsibilities, and Restrictions Worksheet**

- This worksheet can help you complete rights and restoration plans that are to be included under the “Needs, Risks, and Restrictions” section in your IPC. Remember is any right is restricted due to behaviors; you are required to complete a Positive Behavior Support Plan.

### **Sample Child Individualized Plan of Care**

### **Sample Adult Individualized Plan of Care**

- These are samples of fictional Participant’s IPC to help illustrate the documentation required to complete the IPC particularly the “Individual Preferences”, “Risks, Needs, and Restrictions”, and Service Authorization” sections.

## **Self Direction**

- [Good & Services](#)
- [Unpaid Caregiver Training](#)
- [Request Goods & Services through Self-Direction](#): Step by Step Instructions

## **Specialized Equipment Worksheet**

- Specialized Equipment Service worksheet is to assist teams in determining whether an item will meet the covered items in Chapter 44 of Medicaid rules.

## **Supervision Level and/or Intervention Request Form**

- This request form is not required if the team believe a less intense support level will meet the Participant's needs and will encourage greater independence.
- If the Participant requires higher support than in his/her previous IPC, a "Supervision Level and/or Intervention Request" form must be submitted and the IPC information must substantiate the support tier requested. Form is uploaded under "Needs, Risks, & Restrictions" link in the Habilitation Support Area.
- Support levels with tiered rates apply to Residential and Day Habilitation. Intervention units can be added to these services only.
- For more specifics advance to pages 95-96.

## **Team Meeting Checklist Checklist**

- The [Team Meeting Checklist](#) is a handy guide to help Case Managers get organized and prepared for the annual IPC meeting and 4-6 month team meetings.

## **Transition Checklist Checklist**

- The [Transition Policy & Procedure](#) must be followed and the Transition Checklist submitted if the modification is a change in case manager, residential placement, or day services. Upload the checklist in the "Document Library".

## **Waiver Application & Eligibility Guide for Adult & Child DD Waivers Guide**

- This guide provides the details for the Adult and Child DD waiver eligibility and application process.

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- **Supervision Level and/or Intervention Request form is used, if one of the following applies:**

1. Participant has not received Residential or Day Habilitation before and the Support level corresponding to his/her ICAP Service Score is not indicative of the support needed.

2. Participant needs more support than provided on last year's approved IPC due to health and safety reasons.

3. A new ICAP Service Score reflects a different support level, which the team states is the actual support level needed for the Participant's health and safety.

NOTE: A newer ICAP service score does not automatically assure a different support level.

4. The team is requesting more intervention to meet the Participant's health and safety needs.

- **When using the form above to justify a request for a higher support level, the habilitation Provider is required to:**
  1. Identify the current ICAP Service Score and the approved Support/Supervision level in last year's IPC.
  2. Indicate the support/supervision level which would be more appropriate.
  3. Provide an explanation for the different level being requested and how it will meet the Participant's health and safety needs. Then indicate:
    - a. The number of Participants in the home or Day Habilitation setting
    - b. The number of staff routinely assigned to that setting
    - c. If additional staff would be available for parts of the day, then describe the type of activity, the number of staff assigned, and the length of time they are present.**Support level is subject to approval by the Division.**
  4. Use the Intervention request to describe how the Intervention staff is accessed and his/her Intervention duties. (Intervention units cannot be supplied by someone routinely assigned to the unit who has regular supervision duties with other Participants at the same time.)
    - a. Describe how the additional staffing Intervention will be documented by the Provider, verifying the additional support is being provided to the Participant.

5. When using the form to justify the use of Intervention units, the habilitation Provider is required to:
  - a. Provide the answers to the questions in #3c above.
  - b. Indicate the number of Intervention units being requested.
  - c. Describe the behavioral, health, safety, medical, and/or Personal Care issues that would require a more intensive support level. See [Figure A-1](#) and [Support Level Descriptions](#) for additional guidance.
  - d. If the activity is episodic and not schedule driven, explain the types of episodes and the frequency of such behaviors or needs.
  - e. Detail intervention utilization by staff. Specify the behaviors or needs requiring intervention.
6. This form shall be submitted to the Division for review and approval with the annual IPC.
  - a. This form may also be submitted as part of a modification request to the IPC. **Intervention units are subject to approval by the Division.**
  - b. If approved, then the IPC will need:
    - i. The support level descriptions in the “**Habilitation Supports**” section under “Rights, Needs, and Restrictions” in the EWMS to reflect the same requested support level.
    - ii. If it is a modification to a current plan, then the “**Habilitation Supports**” section may be changed after the request is approved.
    - iii. For approved Intervention, an Intervention schedule will be needed to reflect the higher support level/Intervention.
  - c. If the justification request is denied, the Division will send a denial in writing, and
    - i. The support levels on the pertinent sections of the plan of care will need to be changed to the approved support level.
  - d. If the IPC cost exceeds the IBA, submit an [Individual Budget Amount \(IBA\) Adjustment Request](#) form and refer to instructions noted above.

## Chapter 6 – Glossary

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#### **Advocate**

Person who exercises his/her right to be heard on matters important to him or her, or represents another person's plea or cause.

#### **Antecedents**

Actions or statements that take place before a targeted behavior occurs.

#### **Baseline data**

Performance-based information gathered before a program begins. It is used later to provide a comparison for assessing program impact.

#### **Conflict of Interest**

Specific to the IPC, a conflict of interest is a situation in which a Case Manager has competing or conflicting interests or loyalties. Examples include:

- A self-employed Case Manager also provides other services on that Participant's IPC.
- An organization employs a Participant's Case Manager, and also provides other services on the Participant's IPC.

#### **Cue**

Any signal, statement, gesture, or action identified, which should be followed with a specific action.

#### **Data**

Multiple facts used as a basis for inference, testing, models, etc.

#### **Dignity**

Bearing, conduct, or speech indicative of respect, appreciation of an occasion or situation and showing a person they are capable, worthy and valuable.

#### **Emerging behaviors**

Actions or statements that arise from a participant before targeted behaviors usually occur.

#### **Enclaves**

Enclaves typically consist of a group of individuals with disabilities working together under the supervision of an agency employee in a community business or industry. There is a contractual

relationship between the business and the agency, and the agency pays the workers with disabilities at or above minimum wage.

### **EMWS**

Electronic Medicaid Waiver System – a web-based electronic application used to manage waivers.

### **Functional behavioral analysis**

Information gathered relating to the what, when, where, who and why of the targeted behaviors. Information is gathered through direct observation of the Participant's targeted behaviors as they emerge and decline, interviews with people familiar with the Participant who can give details on preliminary or emerging behaviors before the targeted are witnessed, pertinent history relating to the behaviors, possible causes of the behaviors, and an evaluation of the environments where targeted behaviors take place.

### **Intervention**

Intervention units can be added to Residential and Day Habilitation services when a Participant's regular support level may not provide sufficient staffing for specific activities included in the IPC, but the support level is not needed at all times.

### **Medication Assistance Record (MAR)**

Form containing the Participant's name, allergies, medication name(s), dosage (including strength or concentration of the medication), administration route, special instructions, date and time of the medication assistance needed, and signature of the Provider assisting with medications.

### **PRN**

Medical term meaning a medicine given as the occasion arises, or when necessary.

### **Participant**

An individual who has been determined eligible for covered services on the Waiver.

### **Person-centered planning**

A process directed by a Participant that identifies the Participant's strengths, capacities, preferences, needs, services which may meet the needs, and providers available to provide services. Person-centered planning allows a Participant to exercise choice and control over developing and implementing the plan of care.

### **Positive Interventions**

An action by a person that changes a course of events or targeted behaviors by a Participant, characterized by displaying approval, acceptance or affirmation.

**Positive Behavior Supports**

Multiple approaches with a person, such as changing systems, altering environments, teaching skills, and appreciating positive behavior, in hopes of avoiding a target behavior.

**Protocol**

A detailed plan of treatment, or procedures/directions to follow for a specific event, such as a medical, seizure, or behavior plan protocol.

**Provider**

A person or entity that is certified by the DD to furnish covered services and is currently enrolled as a Medicaid Waiver provider.

**Replacement behaviors**

Acceptable behaviors and actions taught to a Participant as an alternative way to communicate needs and wants, respond to a situation, event, or problematic environment rather than displaying the targeted behavior(s).

**Restraint**

A personal, mechanical, or drug used as to restraint as defined in Chapters 41- 45 of Medicaid rules.

**Restriction**

A condition that limits a right of a person, keeps a person or possession within certain boundaries, or controls behavior with a physical, mechanical, or a drug used as a restraint.

**Staff**

Any employee of a Medicaid provider, usually referring to a person who provides direct care to a Participant.

**Targeted behaviors**

Specific behavior the Participant or the team would like to change or extinguish. Things for the team to consider: *Does the current behavior impact the goals of the plan? What behavior should replace it? What incentive does Participant have to implement the desired behavioral change? What is the desired outcome of the behavioral change, and how is this addressed in the plan of care?*

**Task analysis**

A method used to track measurement on a Participant's objective. It should contain the objective statement, each task involved in achieving the objective, the level of support needed for completing a task, and a system to measure achievement on each task and overall measurement on the objective.

## Online Resources [BACK TO INDEX](#)

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### A. Department of Health; Behavioral Health Division Rules

- [Chapter 1](#), Rules for Case Management

### B. Department of Health; Wyoming Medicaid Rules

- [Chapter 1](#), Definitions **NEW!**
- [Chapter 3](#), Provider Participation
- [Chapter 4](#), Medicaid Administrative Hearings **REVISED!**
- [Chapter 16](#), Medicaid Program Integrity **REVISED!**
- [Chapter 26](#), Medicaid Covered Services
- [Chapter 34](#), Home and Community Based Waiver Services
- [Chapter 35](#), Medicaid Benefit Recovery
- [Chapter 41](#), Adult Developmental Disabilities Home and Community Based Waiver
- [Chapter 42](#), Child Developmental Disabilities Home and Community Based Waiver
- [Chapter 43](#), Adult Acquired Brain Injury Home and Community Based Waiver
- [Chapter 44](#), Environmental Modifications and Specialized Equipment For Home and Community Based Waiver Services
- [Chapter 45](#), Waiver Provider Certification and Sanctions

### C. Department of Health; Behavioral Health Division, Developmental Disabilities Section

- [Online Training Modules](#)
- [DD Sections website](#)

### D. Department of Health; Division of Healthcare Financing

- [Billing](#)
- [Void/Adjustment form](#)

### E. Self-Direction

- [Public Partnerships Limited \(PPL\)](#)
- [DD Sections website provides more information on Self-Direction](#)

# Waiver Services Definitions

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This Waiver Service Definition summary is for the Adult Developmental Disabilities (DD), Child DD, and Acquired Brain Injury (ABI) Waivers.

List of services and changes to existing services are **effective JULY 1, 2011 through June 30, 2012.**

<b>Case Management</b> <a href="#">Back to TOC</a>	<b>Note this change:</b> If a relative provides any services to a related waiver participant, the plan of care shall be developed and monitored by a case manager without a conflict of interest to the relative provider or the participant, which means the case manager shall not be employed by or related to the relative provider or the participant (i.e. Sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant’s guardian). ALSO, note the transition plan listed.	<b>Rate:</b> <b>\$271.58/</b> <b>month</b>	<b>All</b> <b>Waivers</b>
<b>Definition:</b> Case management is a service to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.			
<p><b>Case managers are responsible for the following functions for participants choosing NOT to self-direct services: (Traditional case management)</b></p> <ul style="list-style-type: none"> <li>• Assessment and/or reassessment of the need for waiver services;</li> <li>• Initiating the process to evaluate and/or re-evaluate the individual's level of care</li> <li>• Linking waiver participants to other Federal, state and local programs;</li> <li>• Development of the plan of care adhering to the Division’s policies and procedures;</li> <li>• Coordination of multiple services and/or among multiple providers;</li> <li>• Ongoing monitoring of the implementation of the plans of care;</li> <li>• Ongoing monitoring of participants’ health and welfare;</li> <li>• Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant’s health and welfare;</li> <li>• Responding to participant crises;</li> <li>• Reviewing service utilization and documentation of all services provided on a monthly basis to assure the amount, frequency, and duration of services are appropriate.</li> </ul> <p>The case manager is required to complete the following responsibilities <u>monthly</u>:</p> <ul style="list-style-type: none"> <li>• A home visit with the participant present to monitor the participant’s health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.</li> <li>• Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.</li> <li>• Follow-up on all raised concerns or questions by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.</li> <li>• Reviewing service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.</li> </ul> <p><b>Subsequent assessments</b> are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, which is required for continued eligibility, and any other assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. All assessments shall be prior authorized by the Division.</p>			

**Case Managers are responsible for the following functions for participants who choose to self-direct services:**

- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the individual's level of care
- Working with the participant, Support Broker and other team members on development of the plan of care that addresses the participant's needs, and submission of the plan of care to the Division adhering to the Division's policies and procedures;
- Ongoing monitoring of the implementation of the plan of care, including monitoring self-directed services and traditional services;
- Ongoing monitoring of participants' health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare, working with the participant, Support Broker and plan of care team members as appropriate;
- Responding to participant crises;
- Reviewing service utilization and documentation of all services provided on a monthly basis, including all self-directed services, to assure the amount, frequency, and duration of services are appropriate.

The role of the Case Manager is to monitor the implementation of the individual plan of care and provide coordination and oversight of supports but not “hands on” involvement in identifying and securing supports. Those are duties of the Support Broker.

The case manager is required to complete the following monthly:

- A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
- Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
- Follow-up on all raised concerns or questions by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
- Reviewing service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Some participants self-directing services may choose not to have a Support Broker after the first year. This may be because they are skilled enough to complete those tasks themselves (as determined through assessment) or they have natural supports that can assist them. In these cases, the general oversight responsibilities of the case manager are sufficient to monitor the participant's self-direction efforts.

**Scope and Limitations:**

Case Managers shall be reimbursed up to 1 unit per month and shall provide a minimum of 2 hours of documented case management service and have completed a home visit each month in order to bill. Service time may consist of direct participant contact, guardian contact, phone calls to the participant or guardian, monitoring the participant in services, following up on concerns or questions regarding the participant, team meetings, plan of care development or updating, the monthly home visit, and service documentation review.

A relative, parent, legally responsible person, or guardian may provide case management services to their ward/related participant if they meet all the provider requirements and complete the process to become a certified Medicaid Waiver case manager, including signing a Medicaid provider agreement. NOTE: The parent, legally responsible person, or guardian may not receive reimbursement for providing case management services. However, they can be reimbursed for case management services they provide to other Waiver participants, who have chosen them to provide these services.

The parent/stepparent acting as an unpaid case manager shall not have a conflict of interest, which means that he/she cannot be a provider of any other service on the plan of care.

If a relative provides services to a related waiver participant as a service provider, an employee of a service provider, or a self-directed employee, then the case manager on the participant’s plan of care shall not have a conflict of interest to the relative provider or the participant, which means the case manager shall not be employed by or related to the relative provider or the participant (i.e. Sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant’s guardian).

If hiring a relative through self-direction, the participant’s case manager shall not have a conflict of interest with the relative or participant. This means the case manager shall not be a relative of the employee, participant, or the participant’s legal representative.

If a parent/stepparent is hired by a participant age 18 and over, whereas the Parent/stepparent is not operating as the Employer of Record, then the participant shall have an actively involved support broker to ensure that the s/he has engaged in recruitment activities and that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities. In this arrangement, the participant cannot opt out of support brokerage.

Case management services on the waiver can only be billed and reimbursed after the plan of care is approved by the Division. Prior to entrance to the waiver, targeted case management services are reimbursed through the Medicaid State Plan.

**Transition Plan:**

A Participant, who has a relative on his/her plan of care as a service provider, an employee of a service provider, or a self-directed employee, is required to have a case manager without a conflict of interest to the participant or relative provider/employee. The participant will have until December 31, 2011 to switch case managers to one without a conflict, if they have a relative providing service.

## **Independent Support Broker**

### **[Back to TOC](#)**

**Note:**

**Change in limitations**

**Rate:**

**\$9.54/15 min**

**All Waivers \*can be self-directed if**  
choosing an SB who will only serve one participant

**Definition:**

Independent Support Brokerage is a service that assists the participant (or the participant’s legal representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or legal representative, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. The Support Broker offers practical skills training to participants and their legal representatives to enable them to independently direct and manage waiver services. Support Brokers serve at the discretion of the participant and/or their legal representative. Examples of skills training include providing information on recruiting and hiring direct care workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the individual plan of care. This service does not duplicate other waiver services, including case management. Other functions include assisting the participant in:

1. Identifying immediate and long-term needs, preferences, goals and objectives of the participant for developing the individual plan of care.
2. Making decisions about the individual budget.
3. Developing options to meet the identified needs and access community services and supports specified in the individual plan of care.
4. Negotiating rates of payments and written agreements with service providers.
5. Selecting, hiring and training service providers, as applicable.

6. Developing and implementing risk management agreements and emergency back-up plans.
7. Conducting self-advocacy and assisting with employee grievances and complaints.
8. Assisting with filing grievances and complaints to outside entities, including the appropriate Financial Management Service provider and/or Division.
9. Providing information and practical skills training to the participant in the following areas:
  - a. Person-centered planning and its application.
  - b. The range and scope of individual choices and options.
  - c. The process for changing the individual plan of care and individual budget.
  - d. Recruitment and hiring of service workers.
  - e. Management of service workers, including effectively directing, communicating, and problem-solving.
  - f. Participant responsibilities in self-directed services, including the appeal process.
  - g. Recognition and reporting of abuse, neglect, and exploitation.

Support Brokers have responsibility for training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported. Support Brokers must review employee time sheets and monthly Fiscal Management Service (FMS) reports to ensure that the individualized budget is being spent in accordance with the approved Individual Plan and Budget, and coordinate follow-up on concerns with the participant's case manager. Support Brokerage is a waiver service that is funded through the participant's individual budget.

**Scope and Limitations:**

Service is a 15-minute unit. The Developmental Disabilities Division will add up to 320 units of Independent Support Brokerage to a participant's Individualized Budgeted Amount per plan year; partial plans will be pro-rated, if the participant chooses to self-direct some waiver services. Relatives can be a support broker to their related waiver participant, if they are a certified support provider and provide no other service to the participant on their plan. However, a parent/stepparent/legal guardian acting as a support broker cannot be reimbursed. They can be an unpaid support broker for the participant and are subject to the same qualification and monitoring requirements as paid support brokers.

All paid Support Brokers shall be free of any conflict of interest including employment with a certified waiver provider or provision of any other Waiver service to the same participant. An Individual Support Broker hired by the participant shall only serve one participant, unless he/she is chosen to serve one additional sibling in the same household.

Support Brokerage is a required service for the first year a participant or representative self-directs services. After the first year, the participant or representative may opt out of support broker services if he/she meets one of the criteria below and submits a formal request to opt out of Support Broker Services.

Criteria for Opting out of Support Broker Services includes the following, which is captured on a assessment tool completed by the case manager and approved by the Division:

1. Participants or their legal representatives who are self-directing through the Financial Management Service Agency with Choice who demonstrate the ability to choose workers, coordinate the hiring of workers through the Financial Management Service Agency with Choice provider, and coordinate the delivery of services with the Financial Management Service Agency with Choice provider.
2. Participants or their legal representatives self-directing less than \$5,000 of support services who demonstrate the ability to hire, fire, train and schedule workers and review timesheets in a timely manner.
3. Participants or their legal representatives who have successfully self-directed services for one year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

If a participant is hiring a parent/stepparent/legal guardian as an employee of a direct care services, such as respite or personal care, then the participant shall not opt out of support brokerage and must have an actively involved unrelated support broker to ensure that the s/he has engaged in recruitment activities and that there is a responsible person other than the paid parent, who, in addition to the participant, assumes employer responsibilities.

<b>Personal Care</b> <a href="#">Back to TOC</a>	<b>Notes</b> Can be provided by a parent/stepparent / legal representative to a child under 18 if person is a provider, see limitations	<b>Rate:</b> \$3.89/15 min	<b>All Waivers</b> *can be self-directed
<p><b>Definition:</b></p> <p>A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include nursing care and medication administration to the extent permitted by State law.</p> <p>Such assistance may include assistance in performing activities of daily living (ADLs-bathing dressing, toileting, transferring, maintaining continence) and instrumental activities of daily living on the person's property (IADLs-more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation exclusive of the cost of the meal, using the telephone, medication and money management). Transportation costs are not included as part of this service.</p> <p>The participant must be physically present. Personal care shall be provided in the participant's home or on their property. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with his/her case manager.</p> <p><b>Scope and Limitations:</b></p> <p>This is a 1:1 service based on individual needs. Personal care is available to participants of all ages with units based upon need with a maximum cap of 7280 units. Personal care services are included in Companion, Supported Living, and Residential Habilitation services; therefore, Personal Care cannot be provided in conjunction with those services on the same plan. Personal care cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. The amount of personal care services prior authorized by the Division for the legally responsible individual will be based upon individual extraordinary care needs as specified in the individualized plan of care and other assessments.</p> <p>Personal care is not covered as a stand-alone service through the state plan. It can be provided through home health only. A home health provider typically provides services from 8 am to 5 pm. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do, often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need personal care services must utilize providers that can provide the type, amount and flexible hours of services deemed most appropriate for the participant. The waiver service allows the team to find and utilize providers who can best meet the participant's needs.</p> <p>Any relative providers may provide this service.</p> <p><b>RELATIVE PROVIDERS:</b></p> <p>For relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only, as defined by the Division, and cannot exceed four (4) hours per day per participant. Legally Responsible Individuals (parent/stepparent/guardian) of minor children may be a provider of personal care for extraordinary care needs with the same limit of 4 hours a day per participant. It is expected that for those participants living with their families, that the family members will contribute natural support and supervision, similar to how families function. Additional units needed beyond 4 hours a day require additional documentation and shall only be approved by the Division's Extraordinary Care Committee.</p> <p>For personal care provided to participants under age 18 by a legally responsible individual, payment shall only be authorized for extraordinary care services provided by the legally responsible individual provider as documented in the plan of care and align with the assessed needs of the participant which show the need for extraordinary care.</p>			

**Extraordinary care cases shall meet the following criteria:**

1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and either b or c
2. The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. *(Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or*
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and the Developmental Disabilities Division.

If a legally responsible individual is providing personal care to his/her ward, the plan of care shall be developed and monitored by a case manager without a conflict of interest to the legally responsible individual provider or to the participant, which means the case manager shall not be employed by or related to the provider or the participant (i.e. sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian), to ensure the provision of services is in the best interest of the participant.

The plan shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

## Respite [Back to TOC](#)

**Note**  
New limitation noted excluding parents from providing this service

**Rate:**  
\$3.53/15 min

**All Waivers**  
\*can be self-directed

**Definition:** Respite care consists of services provided to participants unable to care for themselves. Respite is intended to be utilized on a short-term basis because of the absence or need for relief of the natural caregiver. Respite must be episodic, for special events when the caregiver needs relief. Respite cannot be used as a substitute for care while the primary caregiver is at work. It cannot be used for daily scheduled supervision. The amount of Respite services authorized shall be based upon need and does not include similar services otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Respite care may be provided in the waiver participant's home, the private residence of a Respite care provider, or in a group home, as long as the staff person in the group home does not have supervision duties to others living in the group home. Respite services shall not cover any cost for room and board. Respite care may include activities that take place in community settings such as parks, stores, recreation centers.

**Scope and Limitations:**

Service is a 15-minute unit with a limit based upon the participant's need and budget limit, not to exceed 7,280 units per plan year if living with family and not to exceed 2500 units per plan if living in residential services with a non-CARF accredited provider. Services provided must be provided as relief of the primary caregiver, should primarily be episodic in nature, and not used when parents or primary caregivers are working. Respite can only be provided to two participants at the same time unless a participant's plan of care requires 1:1 support. Relative providers (excluding parents/stepparents) may provide this service. Providers cannot provide respite services to children and adults at the same time, unless approved in advance by the Division. Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

<b>Residential Habilitation</b> <a href="#">Back to TOC</a>	<b>Note:</b> new limitations regarding relative providers	<b>Rate:</b> daily tiered rates intervention \$6.24/15 minute unit	<b>All Waivers</b>
<p><b>Definition:</b></p> <p>Individually-tailored supports for a waiver participant that assists with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care, protective oversight and supervision.</p> <p>Residential habilitation may be furnished in a home owned or leased by a provider or in the participant’s home (if no unpaid caregivers or adult family members live in the home), where staff provides on-going 24-hour supervision. Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act.</p> <p>Transportation between the participant’s place of residence, other service sites, or places in the community is included in the rate. Payment is not made, directly or indirectly, to members of the participant's immediate family, except as provided in Appendix C-2. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.</p> <p><b>Residential Habilitation Intervention</b> (service only available for participants on Adult DD and ABI Waivers) can be added to a plan for situations where a participant’s supervision level may not provide sufficient staffing for specific activities, but the extensive supervision is not needed at all times. Intervention provides an extra staff person to supervise a participant during times of behavioral episodes, extensive personal care, positioning, health, medical, or safety needs. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.</p>			
<p><b>Scope and Limitations:</b></p> <p>The provision of residential habilitation services includes personal care needs, so plans of care are not approved that include both residential services and personal care or companion services. This service is available for participants ages 18 and up. The participant must be in service a minimum of 8 hours in a 24-hour period (from 12:00am-11:59pm) for the provider to be reimbursed. Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip. Relative providers (excluding parents/stepparents) may provide this service to the participant while in the participant’s residence. Parents or Stepparents, who are the providers or employees of a provider, may provide this service but shall <u>not</u> live in the same residence as the participant.</p> <p>Waiver participants not receiving 24-hour residential services, who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hour Residential Habilitation services if no other services are available through Foster Care Services managed by the Department of Family Services or the BOCES program managed by the Department of Education and if the participant meets one of the following targeting criteria:</p> <ul style="list-style-type: none"> <li>• A substantial threat to a person’s life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Developmental Disabilities Division or Protection &amp; Advocacy Systems, Inc.</li> <li>• Situations where the person’s condition poses a substantial threat to a person’s life or health, and is documented in writing by a physician.</li> <li>• Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person’s condition presents a substantial risk of physical threat to him or herself or others in the home.</li> <li>• Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person’s health and safety, or the health and safety of others in the home.</li> <li>• Situations where the person’s critical medical condition requires ongoing 24-hour support and supervision to maintain the person’s health and safety.</li> <li>• Loss of primary caregiver due to caregiver’s death, incapacitation, critical medical condition, or inability to provide continuous care.</li> </ul>			

<b>Day Habilitation</b> <a href="#">Back to TOC</a>	<b>Notes</b> New limitations added	<b>Rate:</b> 15 minute unit and daily tiered rates intervention \$6.24/15 minute unit	<b>Adult DD and ABI Waivers only</b>
<p><b>Definition:</b>            Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. Individuals in Day Habilitation may be paid for work activities if the focus of the activity is not independent employment but a means to encourage acquisition, retention, or improvement of skills. If an organization is paying less than minimum wage, all wage and hour labor laws will be met. All transportation including trips to and from the residence, therapy, volunteer sites, and any community activities will be included in the rate.</p> <p><b>Day Habilitation Intervention</b> can be added to a plan for situations where a participant's supervision level may not provide sufficient staffing for specific activities, but the extensive supervision is not needed at all times. Intervention provides an extra staff person to supervise a participant during times of behavioral episodes, extensive personal care, positioning, health, medical, or safety needs. Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.</p>			
<p><b>Scope and Limitations:</b>            The daily unit provides for at least 7 hours of service and requires the participant to receive a minimum of four (4) hours of service a day for the provider to bill and shall not exceed five units or days per week.. Units will be based on individual need with the maximum of 15-minute units being 3750 units in a plan year. The plan of care must identify either the daily unit or the 15 minute unit based on the participant's need. Both the daily unit and the 15 minute unit may be on a participant's plan of care but they cannot be used on the same day. If both types of units are on the plan, the maximum dollar amount for units over the plan year cannot exceed the current approved amount for this service. Additional units of the service require additional documentation of need and shall be reviewed on a case by case basis by the Division. All relative providers may provide this service. Day habilitation services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.</p>			
<b>Special Family Habilitation Home</b> <a href="#">Back to TOC</a>		<b>Rate:</b> \$131.72/day	<b>Child DD Waiver only</b>
<p><b>Definition:</b>            Special Family Habilitation Home consists of participant specific, individually designed and coordinated training within a family (other than biological or adoptive parents) host home environment. This service is intended for children birth through 20 years of age. The provider is the primary caregiver and assumes 24-hour care of the individual.</p>			
<p><b>Scope and Limitations:</b>            This service cannot be used in conjunction with Residential Habilitation Training services. The provision of special family habilitation home services includes personal care needs, so plans of care are not approved that include both residential services and personal care services. The participant must be in service a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed. Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip. Relative providers (excluding parents/stepparents) may provide this service.</p> <p>Waiver participants not receiving 24-hour residential services, who are at significant risk due to extraordinary needs that cannot be met in their current living</p>			

arrangement, may request 24-hour Special Family Habilitation Home services if the service is not available through the Foster Care Service managed by the Department of Family Services or the BOCES program through the Department of Education. The participant must meet one of the following targeted criteria:

- A substantial threat to a person’s life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Developmental Disabilities Division or Protection & Advocacy Systems, Inc.
- Situations where the person’s condition poses a substantial threat to a person’s life or health, and is documented in writing by a physician.
- Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person’s condition presents a substantial risk of physical threat to him or herself or others in the home.
- Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person’s health and safety, or the health and safety of others in the home.
- Situations where the person’s critical medical condition requires ongoing 24-hour support and supervision to maintain the person’s health and safety.
- Loss of primary caregiver due to caregiver’s death, incapacitation, critical medical condition, or inability to provide continuous care.

## **Community Integrated Employment** [Back to TOC](#)

**Rate:** individual - \$6.85 /15 min  
group - \$2.73/15 min

**All Waivers**  
\* can be self-directed

### **Definition:**

Supported Employment Service consists of Individual Community Integrated Employment Services and Group Employment Services.

**Individual Community Integrated Employment Services:** Individual Community Integrated Employment services consist of intensive, ongoing support that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disability, need supports to perform in a regular work setting. Individual Community Integrated Employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Individual Community Integrated Employment includes activities needed to sustain paid work by a participant, including supervision and training. When Individual Community Integrated Employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Transportation is included in the reimbursement rate.

Objectives must be identified in the participant's plan that supports the need for continued job coaching. The job coach must be in the immediate vicinity and available for immediate intervention and support.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

**Group Support Employment Services:** Group Supported Employment Services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Group Supported Employment may include assisting the participant to locate a job or develop a job with a community employer. Group Supported Employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Group Supported Employment can include employment in community businesses or businesses that are part of a provider organization. Transportation is included in the reimbursement rate.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

**Scope and Limitations:**

Service available to Child DD Waiver participants 18 years of age and older. Relative providers (excluding parents/stepparents) may provide this service.

Documentation must be maintained in the participant file verifying this service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Service cannot be provided during the school hours set by the local school district.

**Agency with Choice [Back to TOC](#)**

**Note:** Used to self-direct services. Service does not allow for budget authority. Workers are paid the wage set by the Agency.

**Rate:** \$51.62/month

All  
Waivers

**Definition:** The financial management service (FMS) Agency-with-Choice provider operates as co-employer with the waiver participant and/or their legal representative, who serves as the managing employer, for the purpose of ensuring that the necessary employer-related duties and tasks, including payroll are carried out as described below. Service only available to people self-directing at least one service under employer authority. Participants or their legal representatives self-directing services under the Financial Management Service Agency with Choice do not have budgetary authority, including the option to purchase Individual Goods and Services. Participants or their legal representatives who choose to self-direct services must choose either the Financial Management Service Fiscal/Employer Agent or the Financial Management Service Agency with Choice service. Requirements include:

1. Performing accurate and timely payroll services, providing workers compensation insurance and other benefits administration for workers, as applicable pursuant to federal and state rules and regulations.
2. Using generally accepted accounting practices for record keeping.
3. Serving as employer of record for workers employed by the agency including those who are recruited, referred and managed by participants.
4. Processing criminal background checks and Central Registry checks on prospective employees as required or requested.
5. Assuring prospective employees meet the standards for the service being provided, including when applicable, maintaining current CPR and First Aid Certification, participant specific training, general training on recognizing abuse, neglect and exploitation, Division's Notification of Incident process, service

- documentation, HIPAA/Confidentiality, implementing objectives, and complaints/grievance procedures.
6. Receiving, responding to/resolve and track the receipt of calls and grievances from participants and their representatives and service providers, including the reporting of incidents as a mandatory reporter.
  7. Providing services in accordance with the philosophy of self-direction.
  8. Establishing a system for developing and maintaining Agency-with-Choice, participant, service worker, and vendor records and files (both current and archived) that is secure and HIPAA compliant.
  9. Providing the co-employment services serving as the employer of record in which the participant, who is the managing employer has the rights and responsibilities to:
    - b. Recruit and refer prospective workers to the Agency-with-Choice for hire and assignment back to the participant.
    - c. Orient and train workers.
    - d. Determine workers’ terms and conditions of work and work schedules.
    - e. Supervise workers’ day-to-day activities.
    - f. Evaluate workers’ performance.
    - g. Discharge workers as necessary from their work sites (homes).
    - h. Request that the Agency-with-Choice refer workers for consideration and assignment to the participant.
  10. Develop and implement a quality assurance program to ensure continuous quality improvement including measurements of participant satisfaction.
  11. Develop an FMS Agency-with-Choice Policies and Procedure Manual that includes policies, procedures and internal controls for all FMS Agency-with-Choice tasks, including the requirements listed above. This Manual must be completed and reviewed by the Division before the agency can be certified in the Agency with Choice Service and must be updated as needed and at least every 12 months.
  12. A Certificate of Good Standing from the Wyoming Department of Employment, verifying provider is in compliance with the unemployment insurance and Workers Compensation requirements of Wyoming.

**Scope and Limitations:** Service only available to people self-directing at least one direct care service. Relative providers (excluding parents/stepparents) may provide this service.

## **Child Habilitation Services**

[Back to TOC](#)

**Rate:** \$2.78 /15 min (ages 0-12)  
\$3.53 /15 min (ages 13-17)

**Child DD  
Waiver Only**

**Definition:**

Child Habilitation Services provide children with regularly scheduled activities (and/or supervision) for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs in the participant’s local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Service may provide at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as Respite or Personal Care. Service may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families.

Child Habilitation Services also includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting.

Coordination activities may involve the implementation of components of the child's family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Transportation is included in the reimbursement rate.

**Scope and Limitations:**

1. This service is limited to children under age 18.
2. This service is a 15-minute unit. A provider can receive reimbursement for up to two (2) participants at one time, with a limit of three (3) persons being supervised by a provider or provider staff at one time.
3. The rate for this service, for children through age 12, does not include the basic cost of childcare unrelated to a child's disability that may be needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of child care" means the rate charged by and paid to a childcare center or worker for children who do not have special needs. The basic cost of childcare does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service.
4. For children over age 12 through age 17, the rate for the service shall have a modifier "add in" component to cover the amount of the child care cost, which is no longer required after age 12.
5. This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA).
6. Child Habilitation Services include personal care services, so providers cannot be reimbursed for providing both services at the same time.
7. Child Habilitation Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.
8. Units shall be limited based upon the participant's need during non-school times and during summer, breaks, etc. A further limit is the participant's budget amount.
9. Relative providers (excluding parents/stepparents) may provide this service.

## Companion Services [Back to TOC](#)

**Rate:** Individual \$3.89/15 min  
Group \$1.50/15 min

**All Waivers  
\*can be self-  
directed**

**Definition:** Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services. Transportation is included in the reimbursement rate.

**Scope and Limitations:** This service is available to participants ages 18 and up. It is 15-minute unit and is available as a 1:1 service or a group rate– reimbursable to up to 3 participants. Companion Services provided to participants ages 18 through 21 may not duplicate or replace services that are covered under IDEA and cannot be provided during school hours. With the group rate, providers can provide companion services for up to three participants at the same time. Providers cannot serve children and adults at the same time unless authorized in advance by the Division. Relative providers (excluding parents/stepparents) may provide this service. Companion services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

<b>Unpaid Caregiver Training and Education</b> <a href="#">Back to TOC</a>	<b>Note:</b> Service can only be used if a person is using the Fiscal/Employer Agent FMS – Public Partnership, LLC	<b>Rate:</b> Event	<b>All Waivers</b> *must be self-directed thru PPL
<p><b>Definition:</b> This service enables family members and other unpaid caregivers to gain the knowledge and skills needed to participate more fully in various aspects of caring and advocating for a participant with a disability in their homes, schools and communities. This service includes learning the various techniques and intervention strategies necessary to help a participant to progress, instruction on equipment use as specified in the individual plan of care, and updates as necessary to safely maintain the individual at home. Education includes reimbursement of registration fees for unpaid caregivers to attend seminars and similar opportunities for knowledge dissemination when such opportunities are approved as appropriate. Education must be included in the participant plan of care. Only training and education that is determined to be for the purpose of improving the care of the participant and/or otherwise contributing to the greater welfare of the participant will be approved. Unpaid caregivers are the persons who live with or provide care to a participant on the waiver and may include a parent, spouse, children, relatives, foster family, in-laws, neighbors or other people providing natural supports. This does not include individuals who are employed to care for the participant.</p> <p><b>Scope and Limitations:</b> \$2,000 annual limit. This service is only available for participants self-directing at least one direct care service through the Fiscal Employer Agent FMS option. The limit provides adequate funding for attending a conference, including conference fees and depending on the location provides adequate funding for targeted training by professionals. Service cannot cover the costs of travel, meals and overnight lodging to attend a training event or conference. The Division shall review any request above the specified limit and <i>may</i> approve the request if it is within the person’s individualized budget amount and based upon the health and safety needs of the participant. Criteria for approval above this limit may include that the unpaid caregiver training must address critical health or welfare needs, the unpaid caregiver training is a one-time training to assure unpaid caregivers can fulfill their role successfully reducing the need for waiver services, or other extenuating circumstances. All services must be prior authorized by the Developmental Disabilities Division.</p>			
<b>Individual Directed Goods and Services</b> <a href="#">Back to TOC</a>	<b>Note:</b> Service can only be used if a person is using the Fiscal/Employer Agent FMS – Public Partnership, LLC	<b>Rate:</b> Event	<b>All Waivers</b> *must be self-directed thru PPL
<p><b>Definition:</b> Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care. The service, equipment or supply must:</p> <ol style="list-style-type: none"> <li>1. Reduce the reliance of the participant on other paid supports, or</li> <li>2. Be directly related to health or safety of the participant in the home or community, or</li> <li>3. Be habilitative and contribute to a therapeutic objective, or</li> <li>4. Increase the participant’s ability to be integrated into the community, or</li> <li>5. Provide resources to expand self-advocacy skills and knowledge.</li> </ol> <p>Goods and Services may include:</p> <ul style="list-style-type: none"> <li>• Specialized equipment</li> <li>• Devices, aids, controls, supplies, or household appliances which enable individuals to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and/or community in which s/he lives. Service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.</li> </ul>			

Service includes vehicle modifications but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.

- Transportation provided by family members (excluding parents, step-parents, guardians, or spouses per Wyoming State Statute), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care unless the service includes transportation. The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.
- Home modifications - Physical adaptations which are necessary to ensure the health, welfare, and safety of the individual in the home, enhance the individual's level of independence, or which enable the individual to function with greater independence in the home.
- Camps - May cover cost of the participant attending a camp, and in some cases, an attendant to accompany the person to a camp that he/she could not attend alone and additional staffing was not available at the camp to ensure the person's health and safety.
- Consultation, evaluation and training, and/or a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include participant preferences, health status, medications, conditions and treatments, functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used and/or needed. Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors. Cognitive functioning, including memory, attention, judgment, and general cognitive measures. Environmental factors, including architectural, transportation, other barriers. Social supports and networks, including natural supports. Financial factors, including guardianship or conservatorships, or entitlements that influence the array of supports and services that are needed.
- Consultations and evaluations may be warranted based upon a specific disability, diagnosis, behavior concern, or medical condition relating to the disability. Family members and the person's environment may be involved in the consultation and training, which will help the person increase their health and safety, minimize the use of paid supports, and reduce the likelihood of institutionalization. This consultation and evaluation shall be used by the family and participant's team to better provide both paid and unpaid supports for the participant.

**Scope and Limitations:**

Individually Directed Goods and Services have a \$2,000 annual limit. All goods and services must be prior authorized by the Division and cannot be available through Specialized Equipment or Environmental Modifications on the waiver as specified in Chapter 44 of the Medicaid Rules. The Division may approve requests above the limit if the request meets the specified criteria. Criteria for approving requests above the limit shall include goods or service needs that are due to:

- Unmet needs because of aging out of school
- Documented unavailability of vocational rehabilitation services
- Increasing health concerns that require more services
- Increasing behavioral concerns that require more intervention
- Health needs of unpaid caregivers who cannot continue the historical level of support.

This service is only available for participants self-directing at least one direct care service through the Fiscal Employer Agent FMS option. ***This service may be provided by a relative (excluding parents/stepparents). This service may not duplicate any Medicaid State Plan service.***

**Limitations:**

Modifications to a residence are not approved when the cost of such modifications exceeds the value of the residence before the modification. Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Does not include adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit, nor adaptations that add to the total square footage of the home.

<b>Residential Habilitation Training</b> <a href="#">Back to TOC</a>		<b>Rate:</b> <b>\$29.96/hour unit</b>	<b>Child DD Waiver only</b> <b>*can be self-directed</b>
<p><b>Definition:</b>  Individually-tailored supports that assist a participant with the acquisition of, retention of, or improvement in skills related to gaining more independent living skills. Services are designed to increase or maintain the participant’s skills and independence, and promote self-advocacy.</p> <p>Residential Habilitation Training services are for participants who live with unpaid caregivers or who need less than 24-hour supervision and support. Supports and training objectives may include: adaptive skill development; assistance with activities of daily living; support during transportation; educational supports; and social and leisure skill development. Services include: personal care; assistance with money management; assistance with maintaining social, spiritual and individual relationships; reminding, observing and monitoring medication and pharmacy needs; and providing assistance with the self-administration of medication. This service also includes community access, which is designed to promote maximum participation in community life, support individuals in achieving their desired outcome, promote self-advocacy, and enhance a waiver participant’s ability to control his/her environment through focused teaching of adaptive skills, self-help and socialization skills.</p> <p>Services are provided in integrated settings with persons who do not have disabilities. Community access services cross the lifespan from childhood to adulthood. Supports include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join formal/informal associations and community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests, choice making, and volunteer time. Transportation relating to the participant's Residential Habilitation Training objective, such as trips into the community, shall be provided by the service provider and is included in the rate for the service. This includes services not otherwise available through public education programs in the participant’s local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.</p>			
<p><b>Scope and Limitations:</b>  Residential Habilitation Training is a 1:1 service with an hourly unit, which can be provided in 15-minute increments throughout the day but cannot be rounded to the nearest hour to bill. It is available to participants of all ages on the Child DD Waiver. Relative providers (excluding parents/stepparents) may provide this service. Residential Habilitation Training services have a limit based upon the participant's need and budget limit. For participants through age 21, Residential Habilitation Training services cannot duplicate or replace services covered under IDEA and services cannot be provided during school hours. Residential Habilitation Training cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.</p>			
<b>Homemaker</b> <a href="#">Back to TOC</a>		<b>Rate:</b> <b>\$3.89/15 minutes</b>	<b>All Waivers</b>
<p><b>Definition:</b> Services consisting of general household activities such as meal preparation and routine household care, which are provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home or when the person who usually does these things is temporarily unavailable or unable to perform the tasks. This service does not include direct care/supervision of the waiver participant.</p>			
<p><b>Scope and Limitations:</b> Plan limit is 156 hours, with a maximum of 3 hours per week per household. Service is not available to participants who receive residential habilitation or special family habilitation home services on the waiver. Relative providers (excluding parents/stepparents) may provide this service.</p>			

<b>Supported Living</b> <a href="#">Back to TOC</a>	<b>Note</b> see new limitations on provider type and unit limit	<b>Rate:</b> \$8.35/15 min unit for individual \$3.20/15 min group \$89.66 -Daily unit group	All Waivers, age 18+ *can be self-directed
<p><b>Definition:</b></p> <p>Supported Living Services assist persons with disabilities to live in their own home, family home, or rental unit. These individuals do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence. They require individually-tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community. Supported living services shall be based upon need. These services can include: assisting with common daily living activities; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; teaching the use of the community's transportation system; teaching the use of police, fire and emergency assistance; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life; and 24-hour emergency assistance. This service includes personal care, therefore personal care services cannot be added as a separate service on the plan of care. Transportation is included in the reimbursement rate.</p>			
<p><b>Scope and Limitations:</b></p> <p>The daily unit provides for at least 7 hours of service, requires a minimum of 4 hours a day of services and can be reimbursed for up to three participants. The maximum of 15 minute units will be 5400 units in a plan year for the group rate and 3900 units for the individual rate.</p> <p>All relative providers may provide this service. Services provided by a relative provider residing in the same residence as the participant shall be the 15 minute unit only (not the daily unit) and the maximum units allowed per plan year shall be the cap limit specified in the service definition (3900 units for the individual rate).</p> <p>The plan of care must identify either the daily unit or the 15 minute unit based on the participant's need. Both the daily unit and the 15 minute unit may be on a participant's plan of care but they cannot be used on the same day. If both types of units are on the plan, the maximum dollar amount for units over the plan year cannot exceed the current approved amount for this service. Additional units of the service require additional documentation of need and shall be reviewed on a case by case basis by the Division.</p> <p>This service is available for waiver participants 18 years of age and up.</p>			
<b>Skilled Nursing</b> <a href="#">Back to TOC</a>		<b>Rate:</b> \$18.19/ 15 minutes	All Waivers
<p><b>Definition:</b> Services listed in the plan of care that are within the scope of the State's Nurse Practice Act. Skilled nursing services under the waiver differ in provider type (including provider training and qualifications) from skilled nursing services in the Medicaid State plan.</p>			
<p><b>Scope and Limitations:</b> Skilled nursing on the waiver may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services. Relative providers shall not provide this service.</p>			
<b>Environmental Modifications</b> <a href="#">Back to TOC</a>	<b>Notes</b> relative provider type explained and limitation noted	<b>Rate:</b> Event	All Waivers
<p><b>Definition:</b> Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and</p>			

plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

**Scope and Limitations:**

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Scope and Limitations of this service are found in Medicaid Rule Chapter 44. Participants cannot have both Individual Goods and Services and Environmental Modifications on the plan.

Relative providers (including parents/stepparents) may provide this service in accordance with Chapter 45, adhering to the following requirements:

- They are a certified Medicaid Waiver Environmental Modification Provider; and
- The Division receives at least one other bid from another provider to ensure cost effectiveness.
- The Division may use a third party assess the proposed modification and need for the modification to ensure cost effectiveness.

## **Specialized Equipment** [Back to TOC](#)

**Notes** relative provider type explained and limitation noted

**Rate:** Event

**All Waivers**

**Definition:** Specialized equipment includes:

1. Devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live
3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.
4. Such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and,
5. Necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

**Scope and Limitations:** Limitations of this service are found in Medicaid Rule Chapter 44. Relative providers (including parents/stepparents) may provide this service with the following requirements:

- They are a certified Medicaid Waiver Specialized Equipment Provider; and
- Do not impose a mark up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- Receive at least one other bid from another provider to ensure cost effectiveness.

## **Dietician Services** [Back to TOC](#)

**Rate:** \$14.47/ 15 minute

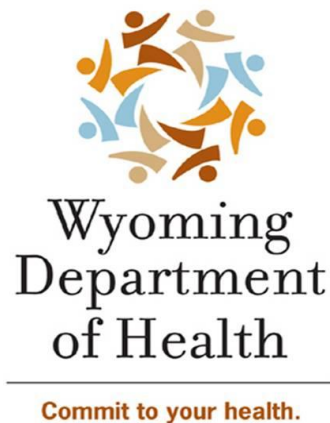
**All Waivers**

**Definition:** Dietician Services provided by a registered dietician include menu planning, consultation with and training for caregivers, and education for the individual served. The service does not include the cost of meals. Dietician Services are not available under the State Plan. Without this service certain individuals would receive inadequate nourishment and would require institutionalization. The Dietician services are those services designated in the participant's Individual Plan of Care (IPC). The clientele served by this service show a pattern of chronic and unusual need requiring Dietician Services, which are not provided by the State Plan. Chronic needs encompass conditions such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses or severe allergies.

**Scope and Limitations:** Limited to services not provided under the Medicaid State Plan. Relative providers shall not provide this service.

<b>Cognitive Retraining</b> <a href="#">Back to TOC</a>		<b>Rate:</b> \$8.10/15 min	<b>ABI Waiver Only</b>
<b>Definition:</b> Training provided to the person served or family members that will assist the compensation or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care (POC).			
<b>Transition Plan:</b> Participants who have this service on their plan will need to modify their plan by June 30, 2010 to switch the units remaining on the plan to the new code. Relative providers shall not provide this service.			
<b>Speech Therapy</b> <a href="#">Back to TOC</a>		<b>Rate:</b> Individual -\$16.95/ 15 min Group -\$6.50/ 15 min	<b>Adult DD &amp; ABI Waivers</b>
<b>Definition:</b> Speech Therapy services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy. Speech Therapy services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician.			
<b>Scope and Limitations:</b> Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.			
<b>Occupational Therapy</b> <a href="#">Back to TOC</a>		<b>Rate:</b> Individual -\$17.19/ 15 min Group -\$6.59/ 15 min	<b>Adult DD &amp; ABI Waivers</b>
<b>Definition:</b> Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, development a treatment plan, determining therapeutic intervention, training and assisting with adaptive aids. Occupational Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Occupational Services are limited to restorative therapy.			
<b>Scope and Limitations:</b> Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.			
<b>Physical Therapy</b> <a href="#">Back to TOC</a>		<b>Rate:</b> Individual -\$21.04/15 min Group -\$8.06/15 min	<b>Adult DD &amp; ABI Waivers</b>
<b>Definition:</b> Physical Therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, irreducible or progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation. Physical Therapy Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Physical Services are limited to restorative therapy.			
<b>Scope and Limitations:</b> Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.			

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Developmental Disabilities Section

# Electronic Medicaid Waiver System

## Individualized Plan of Care User Guide with Modifications

Rev: November 2012

**Adult DD**  
**Child DD**  
**ABI**  
**Waivers**

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# Electronic Medicaid Waiver System

## Introduction – [BACK TO TOC](#)

This **guide is associated with the Individualized Plan of Care process** for a Medicaid waiver administered by the Developmental Disabilities Section for the following waivers:

1. Adult Developmental Disabilities (ADD)
2. Child Developmental Disabilities (CDD)
3. Acquired Brain Injury (ABI)

This is a **user-friendly Electronic Medicaid Waiver System (EMWS)** and after working through this guide, Users should be able to navigate confidently and manage successfully all assigned tasks.

**Screen shots are provided detailing the tasks for each specific User** in the electronic waiver eligibility process. Each task is assigned to a specific User and the User will be referenced for each task in this guide.

The specific Users in this system with definitive roles are the following:

11. **Case Manager (CM)**
12. **Participant Support Program Manager** – Developmental Disabilities Programs
13. **Participant Support Specialist (PSS)** – Developmental Disabilities Programs
14. **Provider Support Specialist** – Developmental Disabilities Programs
15. **Medicaid Eligibility Staff** – Department of Family Services (DFS)
16. **Medicaid Eligibility Supervisor** – Department of Family Services (DFS)
17. **Wyoming Institute for Disabilities (WIND)** – University of Wyoming

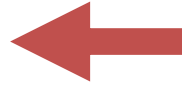
After a task is completed by one of the above assigned users, the system automatically sends the case to the next user in the working queue with an assigned role. This role-based processing is referred to as workflow. Users are notified via email when they have a task pending completion.

**Thus, the purpose of this guide is to help illustrate all the tasks involved in the workflow and to explain how each User contributes to the overall process and completion.**

## Log In – [BACK TO TOC](#)

The website address to log into the EMWS is:

<https://waivers.health.wyo.gov>



## User Name and Password

The DD Program Manager will distribute user name and password securely to each User as this electronic system adheres to Protected Health Information security.

- **Enter User Name and Password**
- **Click Login** or press enter



**NOTE:** Users are encouraged to store their user name and password in a secure place. In the event User has forgotten user name or password, email [ragen.latham@wyo.gov](mailto:ragen.latham@wyo.gov) or [rita.munoz@wyo.gov](mailto:rita.munoz@wyo.gov).

## Medicaid Waiver System Confidentiality Agreement – [BACK TO TOC](#)

When **logging into the EMWS for the first time and every 90 days thereafter**, User is presented with the **Medicaid Waiver System Confidentiality Agreement** known as an End License User Agreement (EULA).

Each User is responsible for reviewing and adhering to the terms and conditions of the EULA.

**Please be familiar with all 26 agreements especially #6 as follows:**

**REPORT OF UNAUTHORIZED USE**

Each Authorized User agrees to report to WDH any use or disclosure of the Services not provided for by this Agreement immediately following the discovery of such unauthorized use or disclosure. Each Authorized User agrees that upon any event which may compromise the security of his or her account, including without limitation, the loss, theft, or unauthorized disclosure or use of a subscriber login and password that the Authorized User will immediately change his or her password and immediately call:

The WDH Information Technology Service Desk at 1-307-777-5940, and the WDH Compliance Office at 1-307-777-8664 or 1-866-571-0944.

**I Accept** **I Do Not Accept**

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➤ Upon Agreement, **User clicks the “I Accept”** to continue



**NOTE:** For security purposes, the **system times out after 20 minutes of idle time**. User is required to log in again. In most cases, User is returned to the last screen they were on when logged out.

## Task List Tab– [BACK TO TOC](#)

The first screen after logging in will **default to the Task List tab**, showing the User's **active working queue**, which lists the cases and their status identifying assigned tasks. The working queue is called a "grid" and each grid contains up to 10 entries. The window below the active working queue reveals the cases the User is assigned; however, no action is required. This is designed to help Users keep track of where a case is in the workflow process.

**NOTE: Case Managers will only see the Task List, Search Cases, and Admin tabs.**

**5 tabs**

1. **Task List**  
CM & PSS
2. **Search Cases**  
CM & PSS
3. **Waitlist**  
PSS
4. **Reports**  
PSS
5. **Admin**  
(Only Users with Administrative privileges have access to this tab.)

**Working Queue**

**Task List**  
Show Filter

Cases not assigned to you that do not require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status
	Jones	Mary	XXX-XX-7866		DDD - ABI	Plan Of Care	Submit Plan Of Care
	Test	Bill	XXX-XX-3312		DDD - ABI	Eligibility	Create Application
	Last 12076	First 12076	XXX-XX-2076	XX-XXXX2076	DDD - Adult	Plan Of Care	Submit Plan Of Care
	Sample	Bill	XXX-XX-3123		DDD - ABI	Activation	MMIS Activation
	namath	Bill	XXX-XX-5456		DDD - ABI	Eligibility	PSS Ineligible Rev

**Task List**  
Show Filter

Cases assigned to you that require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned
	Jones	Mary	XXX-XX-7866		DDD - ABI	Update LT 104	Complete LT 104	Yes

Cases assigned to you that DO NOT require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Smith	Joe	XXX-XX-3123		DDD - ABI	Eligibility	Select Case Manager	Yes	60
	McKee	Eric	XXX-XX-8888		DDD - ABI	Eligibility	Complete LT 104	Yes	53
	Truman	Jeffery	XXX-XX-3984		DDD - ABI	Eligibility	Complete LT 104	Yes	53
	Johnson	Jim	XXX-XX-3444		DDD - ABI	Eligibility	Submit Neuropsych Evaluation	Yes	53
	Masse	Stephanie	XXX-XX-8934		DDD - ABI	Eligibility	Complete LT 104	Yes	53
	Richardson	Jason	XXX-XX-8523		DDD - Child	Eligibility	Submit Psych Evaluation	Yes	52
	Sandwich	Ed	XXX-XX-1231		DDD - ABI	Plan Of Care	Approve Plan Of Care	Yes	48
	Sandwich	Ed	XXX-XX-1231		DDD - ABI	Funding Opportunity	Final Approval	Yes	46
	Jones	Mary	XXX-XX-7866		DDD - ABI	Plan Of Care	Approve Plan Of Care	Yes	42
	Smith	Ed	XXX-XX-2345		DDD - ABI	Plan Of Care	Closed	Yes	42

1 2 3

- **Click the page numbers** in the lower left corner of the grid in the Task List screen to advance to additional pages

## Change User Password– [BACK TO TOC](#)

Click Change Password

Task List

Show Filter

Cases not assigned to you that do not require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Jones	Mary	XXX-XX-7866		DDD - ABI	Plan Of Care	Submit Plan Of Care	No	27
	Test	Bill	XXX-XX-3312		DDD - ABI	Eligibility	Create Application	No	22
	Last 12076	First 12076	XXX-XX-2076	XX-XXXX2076	DDD - Adult	Plan Of Care	Submit Plan Of Care	No	7
	Sample	Bill	XXX-XX-3123		DDD - ABI	Activation	MMIS Activation	No	5
	namath	Bill	XXX-XX-5456		DDD - ABI	Eligibility	PSS Ineligible Review	No	5

Case Managers will initially receive their username and password from the DD Training Coordinator via secure email.



[Logout](#)

### WDH APPLICATION GATEWAY

Old password:

New Password:

Confirm New Password:

[Change Password](#)

#### Matched rules:

- ☒ At least 9 characters
- ☒ Includes a symbol (e.g., !@#\$%^&\*()\_+!~=-'\{}|;:'<>?,.)
- ☒ Includes a number
- ☒ Has lower case letter
- ☒ Has upper case letter

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- **Enter Old Password**
- **Enter New Password twice** – be sure to match rules
- **Click Change Password**



**NOTE:** Users will be prompted to change their password every 45 days.

## Logout- [BACK TO TOC](#)

The screenshot shows the Medicaid Waiver System interface. At the top, there is a navigation bar with 'Favorites', 'MWS', and a 'Logout' button. Below this is a header section with the Wyoming Department of Health logo and the title 'Medicaid Waiver System'. A secondary navigation bar includes 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. The main content area is titled 'Task List' and features a 'Show Filter' button (circled in red) and a 'Contacts' button. Below the buttons, a message states: 'Cases not assigned to you that do not require your direct action.' A table displays a list of cases with columns: View, Last Name, First Name, SSN, Medicaid Number, Waiver, Process, Status, Assigned, and Days. The table contains five rows of data. Below the table, there is a 'Task List' section with a 'Hide Filter' button (circled in red) and a filtering tool with fields for Last Name, Medicaid ID, SSN, Division, Waiver Type, County, Process, and Status.

Click Logout to exit

**Task List**

Show Filter

Cases not assigned to you that do not require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Jones	Mary	XXX-XX-7866		DDD - ABI	Plan Of Care	Submit Plan Of Care	No	27
	Test	Bill	XXX-XX-3312		DDD - ABI	Eligibility	Create Application	No	22
	Last 12076	First 12076	XXX-XX-2076	XX-XXXX2076	DDD - Adult	Plan Of Care	Submit Plan Of Care	No	7
	Sample	Bill	XXX-XX-3123		DDD - ABI	Activation	MMIS Activation	No	5
	namath	Bill	XXX-XX-5456		DDD - ABI	Eligibility	PSS Ineligible Review	No	5

**Task List**

Hide Filter

Contacts

Last Name:  Medicaid ID:  SSN:   
 Division:  Waiver Type:  County:   
 Process:  Status:

## Show and Hide Filter on Task List

- Click **Show Filter** to display a filtering tool to narrow down search results
- Click **Hide Filter** to remove filter

## Select Case in Working Queue

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Jones	Mary	XXX-XX-7866		DDD - ABI	Plan Of Care	Submit Plan Of Care	No	27
	Test	Bill	XXX-XX-3312		DDD - ABI	Eligibility	Create Application	No	22

- Click the icon below the View column to select a case

## Search Cases Tab- [BACK TO TOC](#)

Wyoming Department of Health

Medicaid Waiver System

Task List **Search Cases** Waitlist Reports Admin

Welcome Benjamin Gray Change Password Logout

**Search Cases**

[Search](#)  
[Create Case](#)

First Name:  Medicaid ID:   
Last Name:  Date Of Birth:   
SSN:  Gender:

Search

**Search Cases**

[Search](#)  
[Create Case](#)

First Name:  Medicaid ID:   
Last Name:  Date Of Birth:   
SSN:  Gender:

Search

View	Last Name	First Name	Gender	SSN	Medicaid	Waiver Program	Enrolled
	Jones	Mary	Female	XXX-XX-7866	XXX-XX-7866	DDD - ABI	No

- **Enter search criteria** in Search Cases screen, at least three letters of Last Name
- **Click Search**

If no criterion is entered and Search is clicked, system will show ALL RECORDS in search results. To narrow down the search, enter more data in the Search criterion fields.

## Reason for Accessing File– [BACK TO TOC](#)

To meet HIPAA compliance, Users may be asked to provide a reason why they are accessing a particular record.

The screenshot shows the 'Medicaid Waiver System' interface. At the top, there is a navigation bar with 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. Below this, the 'Enter the reason for accessing this file:' form is displayed. The 'Reason' dropdown menu is highlighted with a red circle, indicating the next step in the process.

- **Click the drop down menu** next to Reason and click the reason for accessing

The screenshot shows the 'Enter the reason for accessing this file:' form with the 'Reason' dropdown menu open. The dropdown menu lists several reasons: 'I am supervising my personnel's work', 'Collecting information for reports', 'I am filling in for assigned personnel', 'I am supervising my personnel's work', 'I have been asked to review this file', 'I have been assigned to this case', 'Other', and 'This case has an outstanding task for my role'. The 'Other' option is selected, and the 'Other Reason Text' field is visible below it.

- **Click the reason** that applies **OR**
- Click Other then enter reason
- **Click Save** →

The screenshot shows the 'Enter the reason for accessing this file:' form with the 'Reason' dropdown menu set to 'I am filling in for assigned personnel'. The 'Save' button is highlighted, indicating the final step in the process.



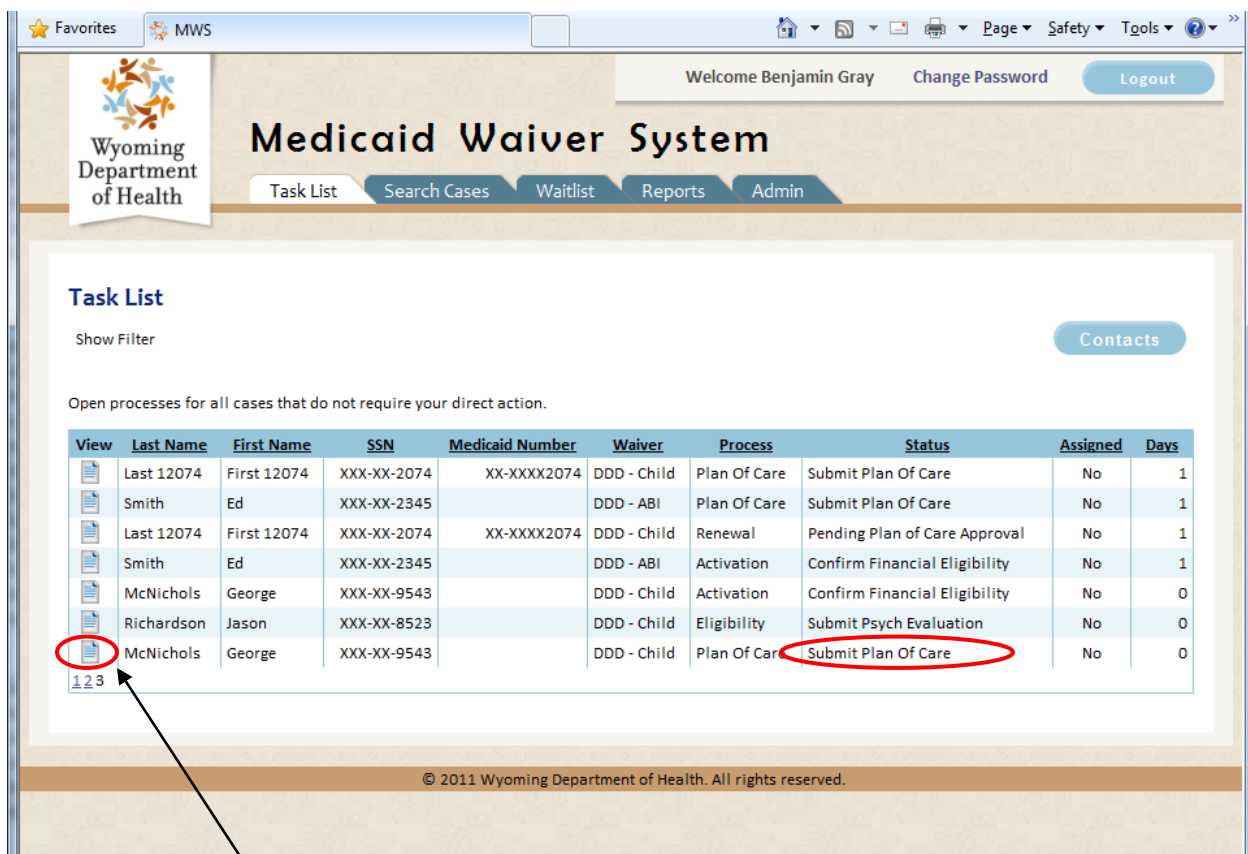
**NOTE:** The system automatically tracks all User activity.

## CM Task List – [BACK TO TOC](#) [OVERVIEW INSTRUCTIONS](#)

When a Participant becomes eligible and is moved off the waitlist, CM will receive an email notification.

When a Participant's Individualized Plan of Care is up for renewal, Case Managers will receive email notification 90-days prior to the expiration date.

After CM logs in, on the CM task list next to the Participant's name "Submit Plan of Care" under Status is shown as noted below.



Task List

Show Filter

Contacts

Open processes for all cases that do not require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Assigned	Days
	Last 12074	First 12074	XXX-XX-2074	XX-XXXX2074	DDD - Child	Plan Of Care	Submit Plan Of Care	No	1
	Smith	Ed	XXX-XX-2345		DDD - ABI	Plan Of Care	Submit Plan Of Care	No	1
	Last 12074	First 12074	XXX-XX-2074	XX-XXXX2074	DDD - Child	Renewal	Pending Plan of Care Approval	No	1
	Smith	Ed	XXX-XX-2345		DDD - ABI	Activation	Confirm Financial Eligibility	No	1
	McNichols	George	XXX-XX-9543		DDD - Child	Activation	Confirm Financial Eligibility	No	0
	Richardson	Jason	XXX-XX-8523		DDD - Child	Eligibility	Submit Psych Evaluation	No	0
	McNichols	George	XXX-XX-9543		DDD - Child	Plan Of Car	Submit Plan Of Care	No	0

1 2 3

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- Click the icon under the View column to open the case

## CM Plan Status– [BACK TO TOC](#) [PLAN STATUS INSTRUCTIONS](#)

After clicking the icon under the View column next to the Participant's name on the Task List, CM is taken to the Plan Status screen shown below. This screen shows the type of Waiver, Participant name, Case Manager, when the plan was initiated and the next action required to process the Plan of Care. There are 10 steps to complete the IPC and this guide will progress through each step, starting with #1 Individual.

The screenshot shows the 'Medicaid Waiver System' interface. At the top, it says 'Welcome Benjamin Gray' with links for 'Change Password' and 'Logout'. The main navigation bar includes 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. Below this, a summary bar shows: Waiver: DDD - Child, Participant: McNichols, George, Case Manager: Nancy Smith. The main content area displays plan details: Plan: 11/9/2011 - 11/8/2012 (Initial), Status: Submit Plan Of Care, Enrollment: 11/9/2011 - 11/8/2012 (Future). A 'History' section shows a table with one entry: Submit Plan Of Care. An 'Action' section has a dropdown menu set to 'Submit to Participant Support Specialist' and a 'Complete' button. A 'Links' section contains a link to the 'Planning Workbook for Individualized Plans of Care'. On the left, a 'Left Navigation Pane' contains two sections: 'Waiver Links' and 'Plan of Care Links'. The 'Plan of Care Links' section has a red circle around the 'Plan Status' link. A red box on the left side of the screen contains text about the 10 steps of the IPC process. A red box at the bottom right contains a reminder about the Planning Workbook. A large image of the 'Planning Workbook' cover is shown on the right side of the screen.

**Left Navigation Pane**

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- **Plan Status**
- Individual
- Demographics
- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

**10 steps involved to completing an IPC.**

**Final step –** CM returns to Plan Status to activate the Action that will move it through to PSS for review & approval.

**Reminder:** Helpful Planning Workbook available online - click link to obtain a copy

**Planning Workbook for Individualized Plans of Care**

Issued Spring 2010

Developmental Disabilities Division  
600 Yellowstone Road Suite 100  
Cheyenne Wyoming 82002 • 307-777-7115 • 800-516-0388  
www.health.wyo.gov/dd

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➤ **Step #1: Click Individual Preferences link in left navigation pane under Plan Mod Links**

## CM #1 Individual Preferences – [BACK TO TOC](#) [INDIVIDUAL PREFERENCES INSTRUCTIONS](#)

On the Individual Preferences screen below, CM fills in the IPC details.

Wyoming Department of Health

# Medicaid Waiver System

Task List Search Cases Waitlist Reports Admin

Waiver: DDD - Child Participant: McNichols, George Case Manager: Aiken, Kirsten

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care  
Enrollment: 11/9/2011 - 11/8/2012 (Future)

### Individual

Plan Start Date: 11/9/2011 Plan End Date: 11/8/2012  
Annual Team Planning Meeting: 9/9/2011 6 Month Review (MM/YYYY): 02/2012

Participant's Desired Accomplishments for the Upcoming Plan Year:  
enter information here....

Participant's Personal Preferences:  
enter information here....

Important Things To Know About Participant:  
enter information here....

Save

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- After completing the information requested on the Individual screen, **click Save**
- Advance to **Step #2: Click Demographics** link under Plan Mod Links



**NOTE:** Clicking Save on these screens, ONLY saves each entry. **To move the case through the process, the CM MUST click the next step** identified in left navigation pane under Plan Mod Links.

## CM #2 Demographics– [BACK TO TOC](#) [DEMOGRAPHIC INSTRUCTIONS](#)

The next step in the IPC is for the CM to complete the information requested on the Demographics screen.

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual
- Demographics
- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

**Participant**

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care  
Enrollment: 11/9/2011 - 11/8/2012 (Future)

**Demographics**

Last Name: Last21520 First Name: First21520  
Middle Name: Suffix:   
SSN: 111121520 Medicaid ID: 00-00021520  
Birth Date: 9/9/1951 Gender: Male   
Ethnicity: White, Not Hispanic Method of Contact:   
Communication Barriers:

**Addresses**

Type	Street Address	City	State	Zip Code
Physical	111 Center St Apt 2B	Cheyenne	Wyoming	82009

**Phone Numbers**

Type	Phone Number	Primary
Home	(307) 667-5762	Yes

**Email Addresses**

Type	Email Address	Primary
Personal	bmcnichol112@yahoo.com	Yes

**Save**

### ➤ Complete the information requested in the Demographics boxes

- Last Name, First Name, Middle Name
- Social Security Number (SSN) & Medicaid ID Number
- Birth Date & Gender
- Ethnicity
- Method of Contact: click down arrow to select preferred way to contact
- Communication Barriers: enter any concerns

## CM #2 Demographics – Address and Phone [Back to TOC](#)

Plan Dates: 12/1/2011 - 11/30/2012 (Future)  
Effective Date: 12/1/2011 (Renewal)  
Print: [Print Icon]

IBA: \$94,219.00  
Status: Submit Plan Of Care

**Participant**

**Address**

Address Type: [Dropdown]  
Address Line 1: [Text Field]  
Address Line 2: [Text Field]  
City: [Text Field]  
State: Wyoming [Dropdown]  
Zip Code: [Text Field]

Save Cancel

Type	Street Address	City	State	Zip Code	
Physical	33226	Thermopolis	Wyoming	82443	✗
Mailing	33227	Thermopolis	Wyoming	82443	✗
Physical	42142	Powell	Wyoming	82435	✗

Add

- **Click Add** in the **Address** box to open the above Modal screen and enter the requested address information
  - After all data has been entered, **click Save**
  - **Click Add** again to enter additional addresses and click Save after each entry

- **Click Add** in **Phone** box
  - Select phone Type
  - Enter Phone Number
  - Check if primary number
  - **Click Save** after each entry
  - **Click Add** again to enter additional Phone Numbers

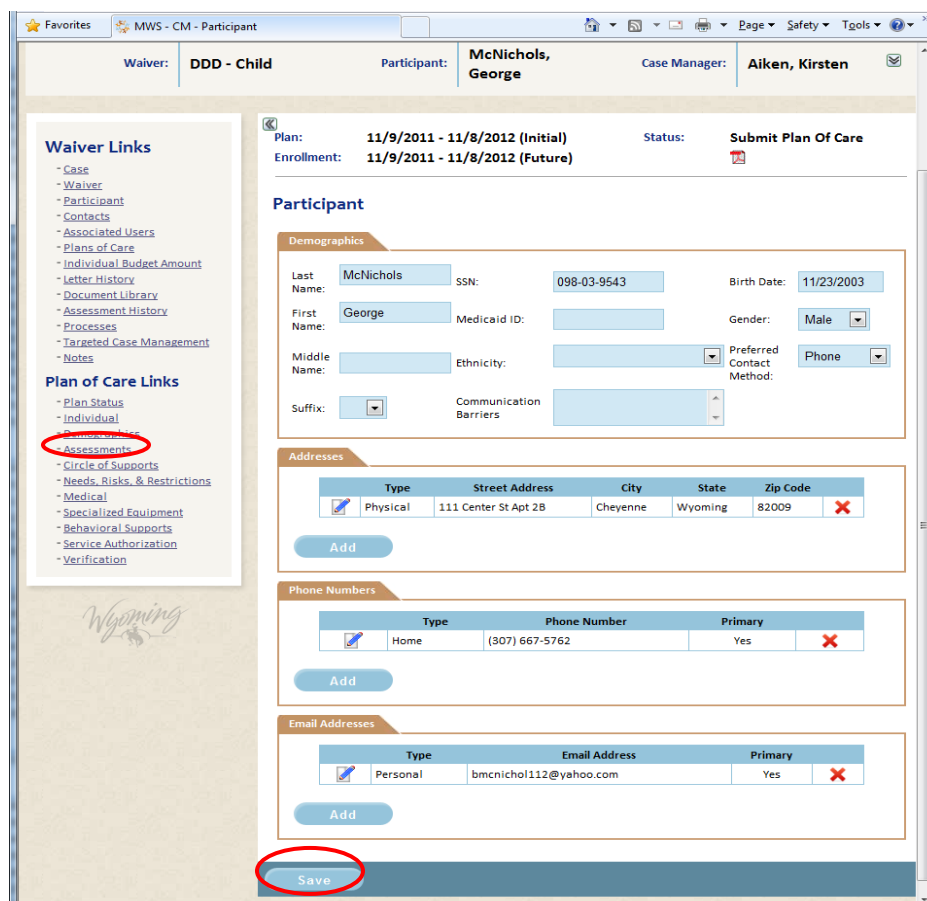
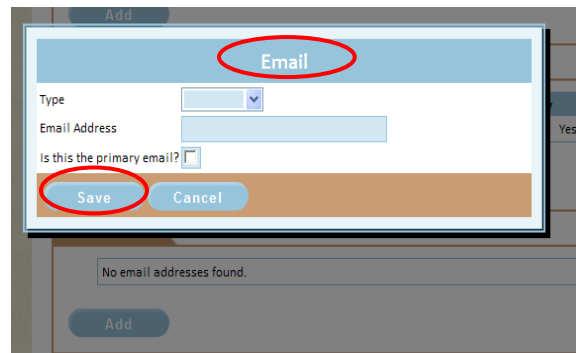
**Phone**

Type: [Dropdown]  
Phone Number: [Text Field]  
Is this the primary phone? [Checkbox]

Save Cancel

## CM #2 Demographics – Email & Finish [Back to TOC](#)

- **Click Add** in **Email** box
  - Select email Type
  - Enter Email Address
  - Check if primary email address
  - **Click Save** after each entry
  - **Click Add** to enter additional email addresses



Waiver: DDD - Child Participant: McNichols, George Case Manager: Aiken, Kirsten

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care  
Enrollment: 11/9/2011 - 11/8/2012 (Future)

**Participant**

**Demographics**

Last Name:	McNichols	SSN:	098-03-9543	Birth Date:	11/23/2003
First Name:	George	Medicaid ID:		Gender:	Male
Middle Name:		Ethnicity:		Preferred Contact Method:	Phone
Suffix:		Communication Barriers:			

**Addresses**

Type	Street Address	City	State	Zip Code
Physical	111 Center St Apt 2B	Cheyenne	Wyoming	82009

**Phone Numbers**

Type	Phone Number	Primary
Home	(307) 667-5762	Yes

**Email Addresses**

Type	Email Address	Primary
Personal	bmcnichol112@yahoo.com	Yes

**Save**

- **Click Save** when all information has been updated under Demographics
- Advance to **Step #3: Click Assessments** link under Plan Mod Links

### CM #3 Assessments– [Back to TOC](#) [Assessments Instructions](#)

Use the “Assessments” link under Waiver Links to upload the Psych or Neuropsych evaluation and 3 pages ICAP report (if the ICAP data is not already in the EMWS).

**ICAP is the only assessment that allows for an Express Update.** Express Update means the CM can transcribe the data from the current ICAP and enter it into the EMWS. **Click “Express Update”** to enter an ICAP assessment data prior to February 2012 that is still valid – expire every 5 years. **Click “Update”** to request approval from your PSS for new ICAP.

After the PSS approves the ICAP request, it goes to WIND to complete the data in the EMWS. Next it moves to PSS for approval and shows up in the “Assessment” link under Waiver Links if approved. **CM is not notified via email when the ICAP has been completed**; therefore, CM must routinely check the Assessments link to see if it has been approved.

Department of Health

Task List Search Cases Admin

Waiver: DDD - CDD Participant: Last19731, First19731 Case Manager: AGUIRRE, LISA

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual Preferences
- Demographics
- **Assessments**
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization

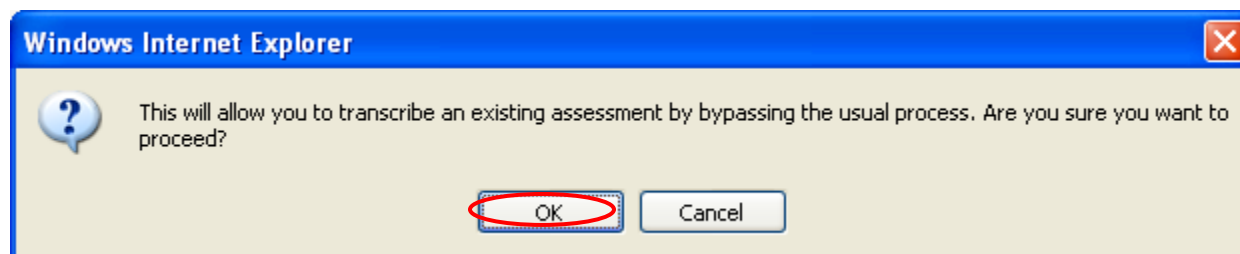
Plan Dates: 1/1/2012 - 12/31/2012 (Future) IBA: \$28,000.00  
Effective Date: 1/1/2012 (Renewal) Status: Approve Plan Of Care  
Print: [Print Icon]

**Assessments**

Type	Evaluation Date	Status	Update	Express Update
LT 104		No Assessment on file	<a href="#">Update</a>	
Psych		No Assessment on file	<a href="#">Update</a>	
ICAP		No Assessment on file	<a href="#">Update</a>	<a href="#">Express Update</a>

**NOTE:** CM will receive an email notification 90 days prior to the IPC expiration date and can access this screen to determine if an ICAP has expired and a new one is due. Steps to initiate a new ICAP request are noted above.

- Click **Express Update** on the ICAP row to transcribe current ICAP data



- Message box pops up asking CM if they would like to proceed, **click OK**

## CM #3 Assessments – ICAP Express [Back to TOC](#) [ICAP INSTRUCTIONS](#)

Click “Express Update” to enter an ICAP assessment data prior to February 2012 that is still valid – it has not expired. After clicking Express Update, the following ICAP screen opens. CM will transcribe the data directly from the current ICAP if not already in the EMWS then upload the three pages ICAP using the [File Naming Convention](#) in “Assessments” under Waiver Links.

- **Click Browse** and upload the three page ICAP report
- **Complete the ICAP Details** – enter this information directly from the current ICAP
- **Click drop down menus under Problem Behaviors** and click choice that applies
- **Complete the Adaptive Behavior Scores**
- **Add any Diagnoses**
- **Click Save**

## CM #3 Assessments – ICAP Express Finish [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

The screenshot shows the Medicaid Waiver System interface. At the top, there's a header with the Wyoming Department of Health logo and the title 'Medicaid Waiver System'. Below this are tabs for 'Task List', 'Search Cases', and 'Admin'. The 'Admin' tab is active, showing a participant named 'Last20174, First20174' managed by 'ELLIOTT, JENNIFER'. On the left, a 'Waiver Links' sidebar lists various links like 'Case', 'Waiver', 'Participant', etc. The main area is titled 'ICAP' and contains a 'Document' section with a 'Browse...' button and an 'ICAP Details' section with various input fields for 'Evaluation Date', 'Service Score', 'General Score', 'Learning/cognition', 'Mobility', 'Problem Behaviors', and 'Adaptive Behavior Scores'. A red box highlights the 'Action' menu on the left, where 'Submit ICAP Evaluation' is selected, and the 'Complete' button is visible below it.

CM selects the Action  
“Submit ICAP Evaluation”  
after transcribing the ICAP  
data then click Complete

- Select **“Submit ICAP Evaluation”** request under Action then **click Complete**

**ICAP update is complete. To get back to Assessments do the following:**

- Click Plan Enrollments link under Waiver Links
- Click the date (In Progress) under Effective Dates
- Click Assessments link under Plan Mod Links

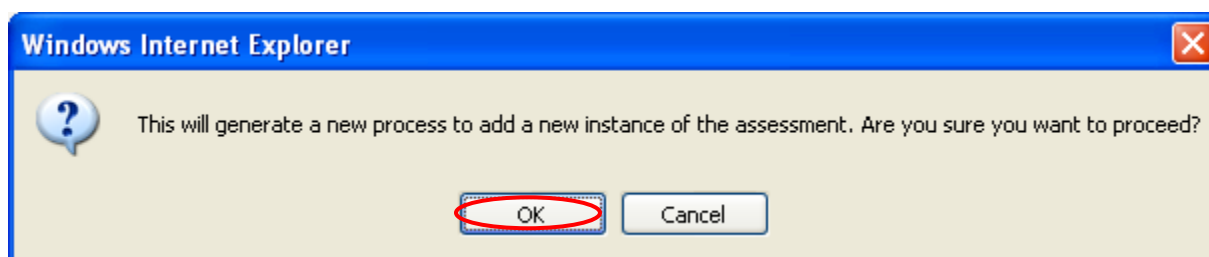
## CM #3 Assessments – LT-104 [Back to TOC](#) [LT-104 INSTRUCTIONS](#)

To update the LT-104, CM can follow the [Waiver Application & Eligibility Guide](#) process. DFS will not need a copy of the LT-104; they can access it directly from the electronic system.

The screenshot shows the EMWS system interface. At the top, there are tabs for 'Task List', 'Search Cases', and 'Admin'. Below these, there are fields for 'Waiver: DDD - CDD', 'Participant: Last19731, First19731', and 'Case Manager: AGUIRRE, LISA'. On the left, there is a 'Waiver Links' menu with options like Case, Waiver, Participant, Contacts, Associated Users, Plans of Care, Individual Budget Amount, Letter History, Document Library, Assessment History, Processes, Targeted Case Management, and Notes. Below this is a 'Plan of Care Links' menu with options like Plan Status, Individual Preferences, Demographics, Assessments, Circle of Supports, Needs, Risks, & Restrictions, Medical, Specialized Equipment, Behavioral Supports, and Service Authorization. The main content area shows 'Plan Dates: 1/1/2012 - 12/31/2012 (Future)', 'Effective Date: 1/1/2012 (Renewal)', 'IBA: \$28,000.00', and 'Status: Approve Plan Of Care'. Below this is an 'Assessments' table with columns for Type, Evaluation Date, Status, Update, and Express Update. The table has three rows: LT 104, Psych, and ICAP. The 'Update' link for the LT 104 row is circled in red.

Type	Evaluation Date	Status	Update	Express Update
LT 104		No Assessment on file	<a href="#">Update</a>	
Psych		No Assessment on file	<a href="#">Update</a>	
ICAP		No Assessment on file	<a href="#">Update</a>	<a href="#">Express Update</a>

➤ **Click Update** on the LT-104 row



➤ Message box pops up asking CM if they would like to proceed, **click OK**

### CM #3 Assessments – LT-104, cont. [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

After CM clicks OK, LT-104 screen appears where CM will complete the data requested. Once the task is completed by the CM, the PSS will review and either approve as clinically eligible, deny indicating not clinically eligible, or rollback requesting clarification, additional info, etc.

The screenshot shows the 'Medicaid Waiver System' interface. The top navigation bar includes 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. The main header displays 'Waiver: DDD - ABI', 'Participant: Last19848, First19848', and 'Case Manager: BURNS, KEVERIN'. The left sidebar contains 'Waiver Links' and 'Update LT 104' sections. The main content area is titled 'LT 104 ICF/ID Level of Care Assessment'. It features a 'Screening Date' field with a calendar pop-up, an 'ICF/ID Admit Date' field, and a 'County' dropdown menu set to 'Teton'. Below these fields are sections for 'Diagnoses' (with an 'Add' button), 'Services Needed' (with a description of criteria), and 'Medical' and 'Psychological' assessment areas with checkboxes for various conditions and supervision needs.

- Click Screen Date box and calendar pops up, **click the date – this is the date CM enters the LT-104 information**
- **DO NOT ENTER ICF/ID Admit Date** – leave blank
- Verify county is correct, if not click down arrow and select correct county

## CM #3 Assessments – LT-104, cont. [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

**Medicaid Waiver System**

Task List Search Cases Waitlist Reports Admin

Waiver: DDD-ABI Participant: Last19848, First19848 Case Manager: BURNS, KEVERIN

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Update LT 104**

Complete LT 104

**Action**

Complete

**LT104 ICF/ID Level of Care Assessment**

Screening Date: ICF/ID Admit Date: County: Teton

**Diagnoses**

No diagnoses found.

**Add**

**Services Needed**

The individual meets at least one criteria in either **Medical** or **Psychological**, and at least one criteria in **Functional**, indicating that the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities and meets ICF/ID level of care.

**Medical**

- ☐ Daily monitoring due to medical condition where overall care planning is necessary.
- ☐ Supervision due to medication effects.

**Psychological**

- ☐ Supervision due to behavior, abusiveness or assaultiveness.
- ☐ Supervision due to impaired judgment and limited capabilities.
- ☐ Supervision due to psychotropic drug effects.

- After Screening Date is entered, **Click Add** in Diagnoses box to enter diagnoses; note multiple diagnoses can be entered by clicking Add

**Diagnosis**

Acquired Brain Injury

Asperger's

Autism

Cerebral Palsy

Down's Syndrome

Epilepsy, grand mal

Epilepsy, other

Epilepsy, petit mal

Mental Retardation - Mild

Mental Retardation - Moderate

Mental Retardation - Profound

Mental Retardation - Severe

Mental Retardation - Severity Unspecified

Other

**Is Qualifying Diagnosis**

**Save** **Cancel**

- **Select the Diagnosis** from drop down menu
- **Check if Qualifying Diagnosis**
- **Click Save**



**Note:** After a licensed psychologist or neurologist determines actual diagnosis, CM may need to change the initial diagnosis to match.

## CM #3 Assessments – LT-104, cont. [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

The screenshot shows the LT-104 assessment form. On the left is a sidebar with 'Waiver Links' (Case, Waiver, Participant, Contacts, Associated Users, Plans of Care, Individual Budget Amount, Letter History, Document Library, Assessment History, Processes, Targeted Case Management, Notes) and 'Update LT 104' (Complete LT 104). Below this is an 'Action' section with a dropdown menu set to 'Submit LT104' and a 'Complete' button circled in red. An arrow points from this 'Complete' button to a text box. The main form area has fields for 'Screening Date', 'ICF/ID Admit Date', and 'County' (set to Teton). Below these is a 'Diagnoses' section with 'No diagnoses found.' and an 'Add' button. The 'Services Needed' section is circled in red and contains a paragraph explaining the criteria for services. It has three sub-sections: 'Medical' (Daily monitoring, Supervision due to medication effects), 'Psychological' (Supervision due to behavior, Supervision due to impaired judgment, Supervision due to psychotropic drug effects), and 'Functional' (A structured and safe environment, Assistance with activities of daily living, Assistance with ambulation, Routine incontinence care, catheter care, or ostomy). Each item has a checkbox. At the bottom of the form is a 'Save' button circled in red.

**Waiver Links**

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plans of Care](#)
- [Individual Budget Amount](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

**Update LT 104**

➡ [Complete LT 104](#)

**Action**

Submit LT104 ▼

**Complete**

**Screening Date:**  **ICF/ID Admit Date:**  **County:** Teton ▼

**Diagnoses**

No diagnoses found.

**Add**

**Services Needed**

The individual meets at least one criteria in either **Medical** or **Psychological**, and at least one criteria in **Functional**, indicating that the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities and meets ICF/ID level of care.

**Medical**

- ☐ Daily monitoring due to medical condition where overall care planning is necessary.
- ☐ Supervision due to medication effects.

**Psychological**

- ☐ Supervision due to behavior, abusiveness or assaultiveness.
- ☐ Supervision due to impaired judgment and limited capabilities.
- ☐ Supervision due to psychotropic drug effects.

**Functional**

- ☐ A structured and safe environment that provides supervision as needed to keep the person safe.
- ☐ Assistance with activities of daily living and self-help skills such as feeding/toileting, dressing and bathing.
- ☐ Assistance with ambulation, mobility.
- ☐ Routine incontinence care, catheter care, or ostomy.

**Save**

CM selects the Action "Submit LT104" after completing all the required LT-104 information then click Complete

- Check the boxes that apply in the Services Needed section
- **Click Save** when finished completing LT-104
- **Select "Submit LT104"** under Actions to move the task to the PSS for review and **click Complete**

## CM #3 Assessments – LT-104 Finish [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

After CM clicks Complete, under Update LT104 a **green** ✓ is next to LT-104 and a **green** ➔ indicates the next pending task by the PSS; Review Level of Care Assessment.

**Department of Health**

Task List Search Cases Admin

Waiver: DDD - CDD Participant: Last19731, First19731 Case Manager: AGUIRRE, LISA

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Update LT 104**

- Complete LT 104
- Review Level of Care Assessment

**LT 104 - ICF/ID Level of Care Assessment**

Comments

Screening Date: 11/17/2011 ICF/ID Admit Date: County: Laramie

**Diagnoses**

Diagnosis	Qualifying	
Mental Retardation - Mild		✗
Seizure Disorder		✗
High Blood Pressure		✗

Add

**Services Needed**

The individual meets at least one criteria in either Medical or Psychological, and at least one criteria in Functional, indicating that the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities and meets ICF/ID level of care.

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plan Enrollments**
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

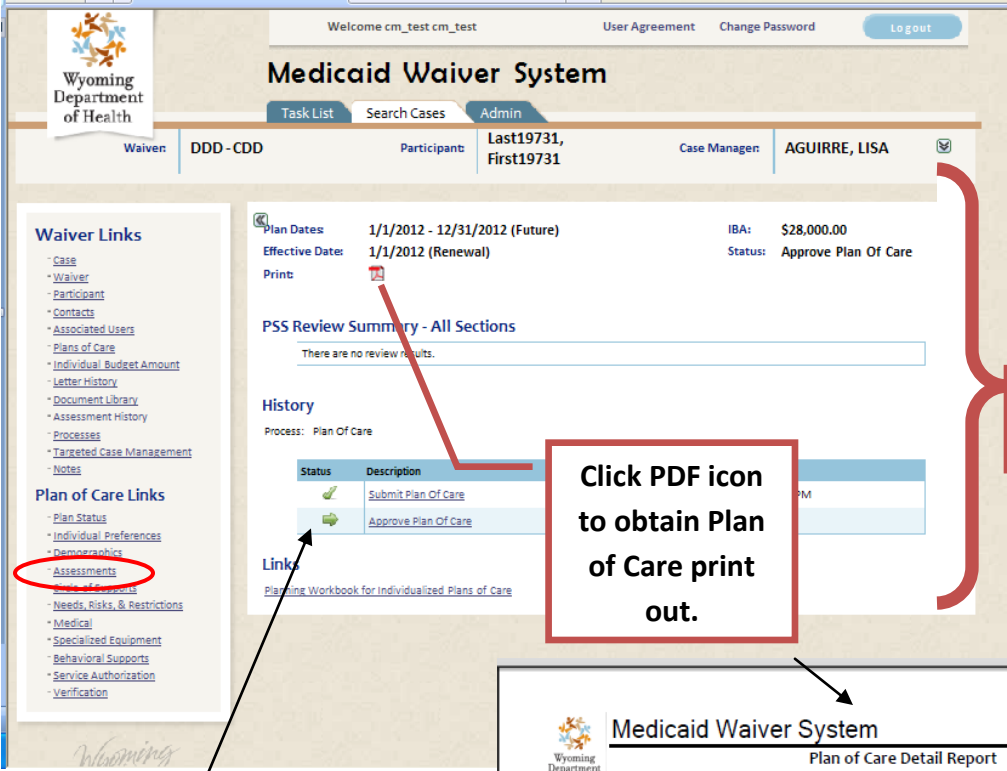
**Plan Enrollments**

Start Date	End Date	End Reason	Modification Effective Dates
12/1/2012	11/30/2013	Future	12/1/2012 (In Progress)
12/1/2011	11/30/2012	Active	12/1/2011, 12/22/2011, 1/11/2012, 9/19/2013
12/1/2010	11/30/2011	N/A	12/1/2010, 11/3/2011, 11/22/2011
12/1/2009	11/30/2010	N/A	12/1/2009
12/1/2008	11/30/2009	N/A	12/1/2008
12/1/2007	11/30/2008	N/A	12/1/2007
12/1/2006	11/30/2007	N/A	12/1/2006
12/15/2005	11/30/2006	N/A	12/15/2005

- To get back to the Assessments, **Click Plan Enrollments** link under Waiver Links
- **Click the date (In Progress)** under Effective Dates

## CM #3 Assessments, cont. [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

Now the CM is back to the Plan Status screen and can finish up the last assessment, Psych or Neuropsych Evaluation.



The screenshot shows the 'Medicaid Waiver System' interface. The top navigation bar includes 'Task List', 'Search Cases', and 'Admin'. The main header displays 'Waiver: DDD - CDD', 'Participant: Last19731, First19731', and 'Case Manager: AGUIRRE, LISA'. The left sidebar contains 'Waiver Links' and 'Plan of Care Links'. The 'Plan of Care Links' section has a red circle around the 'Assessments' link. The main content area shows 'Plan Dates: 1/1/2012 - 12/31/2012 (Future)', 'Effective Date: 1/1/2012 (Renewal)', 'IBA: \$28,000.00', and 'Status: Approve Plan Of Care'. A 'PSS Review Summary - All Sections' section indicates 'There are no review results.' Below this is a 'History' section with a table showing 'Status' and 'Description'. The table has two rows: 'Submit Plan Of Care' and 'Approve Plan Of Care'. A red arrow points from the 'Approve Plan Of Care' row to a text box that says 'Click PDF icon to obtain Plan of Care print out.' Another red arrow points from the 'Assessments' link in the sidebar to a second screenshot of the 'Plan of Care Detail Report'.

**PLAN STATUS SCREEN**

**Click PDF icon to obtain Plan of Care print out.**

**Green ✓ indicates complete – no changes can be made to IPC.**

**Green ➔ indicates the next task to be completed. Changes can be made when the green arrow is visible.**

**Plan of Care Detail Report**

Plan Start Date: 4/1/2011 Plan End Date: 3/31/2012  
Enrollment Start Date: 4/1/2011 Enrollment End Date: 3/31/2012

**Demographics**

Participant	First20174 Last20174	Birth Date	10/7/1972
SSN	111120174	Gender	Female
Medicaid ID	0000020174	Ethnicity	White, Not Hispanic
DFS Number		Communication Barriers	

Address	City	State	Zip Code	Type
31557	Cheyenne	Wyoming	82001	Mailing
31558	Cheyenne	Wyoming	82001	Physical

Phone Number	Type
(307) 156-8221	Home Primary

Email	Type

**Individual Preferences**

Desired Accomplishments

Personal Preferences

- **Click Assessments link** under Plan Mod Links to return to the screen on the following page

## CM #3 Assessments – Psych or Neuropsych [Back to TOC](#) [PSY/NEURO INSTRUCTIONS](#)

Wyoming Department of Health

Welcome cm\_test cm\_test User Agreement Change Password Logout

Task List Search Cases Admin

Waiver: DDD - ADD Participant: Last19757, First19757 Case Manager: AGUIRRE, LISA

Plan Dates: 8/1/2011 - 7/31/2012 (Active) IBA: \$66,643.00  
 Effective Date: 12/1/2011 (Modification) Status: Approve Plan Of Care  
 Print: [Print Icon]

**Assessments**

Type	Evaluation Date	Status	Update	Express Update
LT 104	11/17/2011	In Process		
Psych		No Assessment on file	<a href="#">Update</a>	
ICAP		No Assessment on file	<a href="#">Update</a>	<a href="#">Express Update</a>

**Note: LT-104 now has a status in Process.**

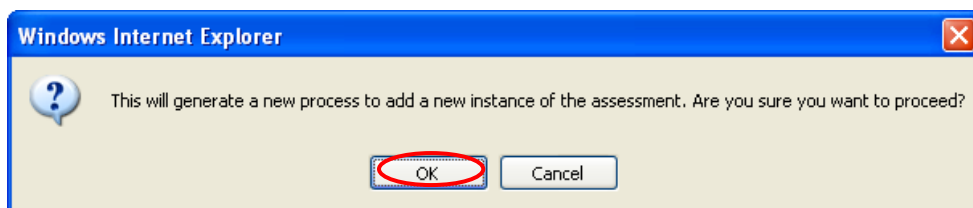
**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual Preferences
- Demographics
- Assessments
- Circle of Support

- **Click Update** on the Psych or Neuropsych row



- **Click OK** in the pop up window  
 (These pop up windows are designed to establish User's attention and ensure the User is aware of the task they have chosen to complete.)

## CM #3 Assessments – Psych Evaluation [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

To update the Psych, CM will follow the Eligibility process, which means CM will enter the data and submit to PSS for review.

The screenshot shows the 'Psych Evaluation' form with several sections and annotations:

- Waiver Links:** A list of links on the left sidebar including Case, Waiver, Participant, Contacts, Associated Users, Plans of Care, Individual Budget Amount, Letter History, Document Library, Assessment History, Processes, Targeted Case Management, and Notes.
- Update Psych:** A section with a 'Submit Psych Evaluation' button and an 'Action' dropdown menu set to 'Submit Psych'.
- Document:** A section titled 'Please upload the Psych evaluation document.' with a 'Browse...' button circled in red.
- Document Information:** A section with fields for 'Evaluation Date', 'Psychologist Name', 'Non-standard IQ' (checkbox), and 'IQ'.
- Diagnoses:** A table with a header 'Diagnosis' and one row containing 'Asperger's' and a red 'X' icon.
- Buttons:** 'Add' and 'Save' buttons are circled in red at the bottom of the form.
- Complete Button:** A 'Complete' button is circled in red in the 'Action' dropdown menu.

A red box on the left contains the text: 'CM selects the Action "Submit Psych" after completing all the required information then click Complete'. An arrow points from this box to the 'Complete' button.

- Upload the Psych evaluation using the [File Naming Convention](#), **click Browse** button to locate file on CM computer
- **Enter the requested Documentation Information** stipulated on the screen
- **Click Add under Diagnosis** to be taken to Modal screen to enter diagnoses  
Diagnosis must also match verified evaluation from licensed psychologists.
- **Click Save**
- Under Action in left navigation pane, **select "Submit Psych"** then **click Complete**

## CM #3 Assessments – Neuropsych Evaluation [Back to TOC](#) [ASSESSMENTS](#)

### [INSTRUCTIONS](#)

To update the Neuropsych, CM will follow the Eligibility process, which means CM will enter the data and submit to PSS for review.

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Update Neuropsych**

Submit Neuropsych Evaluation

**Action**

Submit Neuropsych

**Neuropsych Evaluation**

**Document**

Please upload the Neuropsych evaluation document.

**Document Information**

Date Received

Evaluation Date

MPAI Score

California Verbal Learning Tests Trials 1-5 T Score

Supervision Rating Scale

Brain Injury Date

Brain Injury Cause

Injury Detail

☐ Alcohol Injury

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- Upload the Neuropsych evaluation using the [File Naming Convention](#), **click Browse** button to locate file on CM computer
- **Enter the requested Documentation Information** stipulated on the screen
- **Click Save**
- Under Action in left navigation pane, CM **select “Submit Neuropsych”** then **click Complete**
- **To get back to the Assessments** – after clicking Complete above, Click Plan Enrollments under Waiver Links, click the plan date in progress, click Assessments link

## CM #3 Assessments – Finish [Back to TOC](#) [ASSESSMENTS INSTRUCTIONS](#)

Assessments are finished. Refer to screen below, both LT-104 and Psych are in Process. When “Complete”, this will be noted under Status. The Assessment step is now completed and CM is ready to move to the next step.

The screenshot displays the Medicaid Waiver System interface. At the top, the Wyoming Department of Health logo is on the left, and the system title "Medicaid Waiver System" is centered. Below the title are tabs for "Task List", "Search Cases", and "Admin". The main header area shows "Waiver: DDD - CDD", "Participant: Last19731, First19731", and "Case Manager: AGUIRRE, LISA".

On the left side, there is a "Waiver Links" menu with various options. The "Circle of Supports" link under the "Plan of Care Links" section is circled in red. Other links include Case, Waiver, Participant, Contacts, Associated Users, Plans of Care, Individual Budget Amount, Letter History, Document Library, Assessment History, Processes, Targeted Case Management, Notes, Plan Status, Individual Preferences, Demographics, Circle of Supports, Needs, Risks, & Restrictions, Medical, Specialized Equipment, Behavioral Supports, Service Authorization, and Verification.

The main content area shows "Plan Dates: 1/1/2012 - 12/31/2012 (Future)" and "Effective Date: 1/1/2012 (Renewal)". It also displays "IBA: \$28,000.00" and "Status: Approve Plan Of Care". Below this is an "Assessments" table:

Type	Evaluation Date	Status	Update	Express Update
LT 104	11/17/2011	In Process		
Psych	11/11/2011	In Process		
ICAP		No Assessment on file	<a href="#">Update</a>	<a href="#">Express Update</a>

- Advance to **Step #4: Click Circle of Supports** link under Plan Mod Links



**Note:** DD Sections has developed [online training modules](#) for Case Managers and Providers. There is an excellent training under Module 2 titled ***“Building Natural and Paid Supports”*** designed to better assist CMs at completing the Circle of Supports section in the IPC. Please check it out!

## CM #4 Circle of Supports [BACK TO TOC](#) [CIRCLE OF SUPPORTS INSTRUCTIONS](#)

Next CM completes the Participant's Circle of Supports. **Note:** To *upload Guardian papers*, click Contacts under Waiver Links, click Add or icon next to name of guardian then upload file.

The screenshot displays the EMWS system interface for a participant named George McNichols. The left sidebar contains navigation links under 'Waiver Links' and 'Plan of Care Links'. The 'Circle of Supports' section is currently active, showing options for Home Setting and a list of services. The 'Circle of Support' box is empty, with 'Add' and 'Associate' buttons highlighted. The 'Save' button at the bottom is also highlighted. A red arrow points to the 'Add' button in the top right corner of the 'Contacts' section.

- Check the appropriate boxes in Home Setting box
- Click Add and/or Associate in Circle of Support box
- **Click Save** when complete
- Advance to **Step #5: Needs, Risks, & Restrictions** link under Plan Mod Links

## CM #5 Needs, Risks, & Restrictions [BACK TO TOC](#)

### [NEEDS, RISKS, & RESTRICTIONS INSTRUCTIONS](#)

Next CM will complete the Needs, Risks, and Restrictions. CM is encouraged to use the current [Rights, Responsibilities, and Restriction Tool](#) as a guide.

Waiver: DDD - Child Participant: MICHAEL, George Case Manager: Aiken, Kirsten

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: Submit Plan Of Care  
Enrollment: 11/9/2011 - 11/8/2012 (Future)

### Needs, Risks, and Restrictions

Assessments

Note: Hover over the each field to view detailed information. Complete only the assessments that are necessary for this plan of care

Incomplete Assessments	Support Area	Support Type	Description	Protocols	Comment	Document
	Healthy Lifestyle					
	Financial & Property					
	Meal Time					
	Housing					
	Community					
	Communication					
	Family & Friends					
	Employment/Employment Training					
	Self Care - Personal Hygiene, Bathing					
	Self Advocacy					
	Vulnerability					
	Transportation					
	Mobility					
	Medications & Medical Regimen					
	Physical Conditions					
	Other					

Upload Assessment

Please upload the Assessment form.

If organization uses a general assessment form covering multiple assessments, upload here. This is optional.

- **Click on each applicable pencil icon to edit** – fill out the Modal screen that follows
- **Click Browse** to upload assessment form

## CM #5 Needs, Risks, & Restrictions, cont. [BACK TO TOC](#)

### [NEEDS, RISKS, & RESTRICTIONS INSTRUCTIONS](#)

This is an example of a Needs, Risks, & Restrictions Modal screen for “Family and Friends” showing the drop down menu for protocols when the box is checked.

Any written protocol that lists behavior supports is required to be uploaded using the [File Naming Convention](#) in the “Needs, Risks, and Restrictions” link by clicking the Edit icon then uploading the file in the Modal screen that appears for the Support Area referenced.

The screenshot shows a modal window titled "Family & Friends" for an assessment. At the top, it displays "Waiver: DDD - Child", "Participant: McNichols, George", and "Case Manager: Aiken, Kirsten". The "Assessment" section asks "How will the support be provided?" with checkboxes for "High risk area", "Natural (unpaid) supports", "Non-waiver services", "Restricted due to behavior", "Unmet need", and "Waiver services". Below this, it asks "How to assist the person in this area:" with a text area. The "Protocol(s)" section has a checkbox "this assessment has protocols" which is checked and circled in red. Below this are checkboxes for "Feeding Tube", "Medication Assistance", "Positioning", "Seizure", "Meal Time", "Other", "PRN", and "Vegas Stimulator". A "Comments:" text area is also present. The "Document(s)" section includes an "Upload File" input, a "Browse..." button, and a circled "Upload" button. Below this is a message "No documents uploaded for this service." At the bottom, there are "Save" and "Cancel" buttons, with "Save" circled in red.

- Modal screen has a checkbox to check if “this assessment has protocols” – if checked an additional drop down menu appears. Click the boxes next to the Protocols that apply.
- **Click Upload** using the [File Naming Convention](#) to upload any supporting documentation
- **Click Save** when completed

## CM #5 Needs, Risks, & Restrictions – Example High Risk [BACK TO TOC](#)

### [NEEDS, RISKS, & RESTRICTIONS INSTRUCTIONS](#)

The following two examples illustrate High Risk and a sample of how to assist the Participant in this area. Specify waiver service or natural support and explain how service will be provided.

**Community**

**Assessment**

How will the support be provided?

☒ High risk area ☐ Natural (unpaid) supports ☐ Non-waiver services ☐ Restricted due to behavior

☐ Unmet need ☐ Waiver services

How to assist the person in this area:

Participant does not have safety skills in place, will cross street without looking both directions first.

**Protocol(s)** ☐ This assessment has protocols

**Document(s)**

Upload File  Browse... Upload

No documents uploaded for this service.

Save Cancel

**Financial & Property**

**Assessment**

How will the support be provided?

☒ High risk area ☐ Natural (unpaid) supports ☐ Non-waiver services ☐ Restricted due to behavior

☐ Unmet need ☐ Waiver services

How to assist the person in this area:

This person has a tendency to give away money freely, requires close watch with money.

**Protocol(s)** ☐ This assessment has protocols

**Document(s)**

Upload File  Browse... Upload

No documents uploaded for this service.

Save Cancel

- Advance to Step #6: **Click the Medical** link under Plan Mod Links

## CM #6 Medical [BACK TO TOC](#) [MEDICAL INSTRUCTIONS](#)

CM complete the Medical information for the Participant.

The screenshot displays the 'MWS - Plan of Care - Medical' interface. The top navigation bar includes 'Task List', 'Search Cases', 'Waitlist', 'Reports', and 'Admin'. The participant information shows 'Waiver: DDD - Child', 'Participant: McNichols, George', and 'Case Manager: Aiken, Kirsten'. The 'Plan' is '11/9/2011 - 11/8/2012 (Initial)' and 'Enrollment' is '11/9/2011 - 11/8/2012 (Future)'. The status is 'Submit Plan Of Care'.

**Medical Professional Section:** A text box indicates 'No medical professional found.' Below it is an 'Add' button. A modal form titled 'Medical Professional' is open, showing fields for Name, Phone, Specialty, Primary Medical Professional (checkbox), Address Line 1, Address Line 2, City, State (Wyoming), and Zip Code. 'Save' and 'Cancel' buttons are at the bottom.

**Diagnoses Section:** A table lists diagnoses with pencil icons for editing and red X icons for deletion. The table has columns for 'Diagnosis' and 'Qualifying'.

Diagnosis	Qualifying
Alcohol Dependence	
Asperger's	
Asperger's	

Below the table is an 'Add' button. A text box indicates 'No manually entered medications found.' and another text box indicates 'No medication documents found.'.

**Medications Section:** A text box indicates 'No manually entered medications found.' and another text box indicates 'No medication documents found.'.

**Known Allergies/Serious Reactions Section:** A checkbox labeled 'No Known Allergies' is checked.

**Annotations:** Arrows point to the 'Add' button in the Medical Professional section, the 'Add' button in the Diagnoses section, and the pencil icon for editing or the red X for deleting a diagnosis. A text box says 'Click Pencil Icon to edit or X to delete'.

- **Click Add in Medical Professional** box to add
- **Click Add** in Diagnoses box to add a diagnosis; otherwise **click the pencil icon** to edit or the **red X to delete** a diagnosis

## CM #6 Medical, cont. [BACK TO TOC](#) [MEDICAL INSTRUCTIONS](#)

The screenshot shows a 'Medication' modal form with the following fields: Drug Name, Dose, Route (Oral), Frequency (Scheduled), Purpose (Medical, Psychotropic), and Assistance Required. The form has 'Save' and 'Cancel' buttons. Below the modal, the 'Add' button in the Medications box is circled in red.

NOTE: If related condition, upload document in Document Library. If requires a protocol – upload document in Needs, Risks, Restrictions.

- **Click Add** in the Medications box to add medications
- Modal screen above appears, complete the data requested
  - PRN medications are entered here
- **Click Save** when Modal screen is completed
- **Click Browse to upload medical documents**(including Medication Assistance Record form)

The screenshot shows the 'Medical' form with the following sections: Medical Professional, Diagnoses (with a table for Alcohol Dependence, Asperger's, and Qualifying), Medications, and Known Allergies/Serious Reactions. The 'Save' button is circled in red.

Diagnosis			
<input type="checkbox"/>	Alcohol Dependence		×
<input type="checkbox"/>	Asperger's		×
<input type="checkbox"/>	Asperger's	Qualifying	×

- **Click Save**
- Advance to **Step #7: Click Specialized Equipment** link under Plan Mod Links

## CM #7 Specialized Equipment [BACK TO TOC](#) [SPECIALIZED EQUIPMENT INSTRUCTIONS](#)

CM complete the specialized equipment for the Participant.

The screenshot displays the Medicaid Waiver System interface. At the top, the header includes the Wyoming Department of Health logo, the title "Medicaid Waiver System", and navigation tabs: Task List, Search Cases, Waitlist, Reports, and Admin. Below the header, the user information section shows: Waiver: DDD - Child, Participant: McNichols, George, and Case Manager: Aiken, Kirsten. The main content area is divided into two sections. On the left, a "Waiver Links" sidebar lists various links, with "Specialized Equipment" highlighted in red. On the right, the "Specialized Equipment" section shows a message: "No specialized equipment found." Below this message are two buttons: "Add" and "Save", both of which are circled in red. An arrow points from the "Specialized Equipment" link in the sidebar to the "Add" button. The footer of the page includes the Wyoming logo and the copyright notice: "© 2011 Wyoming Department of Health. All rights reserved."

- **Click Add** and complete the Modal Screen for any specialized equipment
- Continue clicking add to enter multiple equipment
- **Click Save** on each Modal screen
- **Click Save** at bottom of Specialized Equipment when completed
- Advance to **Step #8: Click Behavioral Supports** link under Plan Mod Links

## CM #8 Behavioral Supports [BACK TO TOC](#) [BEHAVIORAL SUPPORTS INSTRUCTIONS](#)

CM complete the Behavioral Supports for the Participant.

Wyoming Department of Health

# Medicaid Waiver System

Welcome Benjamin Gray [Change Password](#) [Logout](#)

[Task List](#) [Search Cases](#) [Waitlist](#) [Reports](#) [Admin](#)

Waiver: **DDD - Child** Participant: **McNichols, George** Case Manager: **Aiken, Kirsten**

Plan: 11/9/2011 - 11/8/2012 (Initial) Status: **Submit Plan Of Care**  
 Enrollment: 11/9/2011 - 11/8/2012 (Future)

### Behavioral Supports

**ICAP Targeted Behaviors**

Behavior Category	Response	Included?	Not included Reason
Unusual or Repetitive Habits	Moderate	Yes	
Withdrawal or Inattentive Behavior	Moderate	Yes	

[Add](#)

**Positive Behavior Support Plans**

There are no Positive Behavior Support Plans.

[Add](#)

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- **Click Add** and complete the Modal screen for **ICAP Targeted Behaviors**
- **Click Add** and complete the Modal screen for **Positive Behavior Support Plan** (includes a Comment section and place to upload document)
- **Click Save** on the Modal screens

**CM #8 Behavioral Supports, cont.** [BACK TO TOC](#) [BEHAVIORAL SUPPORTS INSTRUCTIONS](#)

Follow these steps to edit a Behavior Category:

- Click **“Add”** in the ICAP Targeted Behavior tab
- Click **“No behavior plan needed”**
- In the Comment box that now appears, **document why the behavior is no longer moderately problematic**
  - including the frequency of the behavior and
  - what supports the Participant needs to maintain appropriate behavior for each category of behavior listed
- Click **Save**
- Click **Add** under Positive Behavior Support Plans and complete the checklist
- Click **Browse** to upload a Positive Behavior Support Plan
- Click **Save**
- Advance to **Step #9: Click Service Authorization** link under Plan Mod Links

## CM #9 Service Authorization [BACK TO TOC](#) [SERVICE AUTHORIZATION INSTRUCTIONS](#)

CM enters service authorization information. Service units billed are updated automatically once a week, generally on Sunday's.

**Waiver Links**

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plans of Care](#)
- [Individual Budget Amount](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

**Plan of Care Links**

- [Plan Status](#)
- [Individual](#)
- [Demographics](#)
- [Assessments](#)
- [Circle of Supports](#)
- [Needs, Risks, & Restrictions](#)
- [Medical](#)
- [Specialized Equipment](#)
- [Behavioral Supports](#)
- [Service Authorization](#)
- [Verification](#)

**Plan:** 11/9/2011 - 11/8/2012 (Initial) **Status:** Submit Plan Of Care

**Enrollment:** 11/9/2011 - 11/8/2012 (Future)

**Service Authorization**

**Vision:** N/A

**Preferences:** N/A

**Important Things to Know:** N/A

**Waiver Services**

**IBA**

Individual Budget Amount:	\$12,000.00
Traditional Services:	\$0.00
Self-Directed:	\$0.00
Amount Remaining:	\$12,000.00

**Services**

**Notes:**

- 1) Hover over the Service Code to view the full service name.
- 2) Hover over the icon in the goal column to view the entire Goal.
- 3) Claims information up to date as of 9/28/2012.

**Service Report With PA Information:** **Service Report Without PA Information:**

**Add**

**Self-Directed Services**

No services added.

**Add**

**Goods and Services/Unpaid Caregiver Training**

Must add at least one Fiscal Employer Agent - PPL service in the above section before adding a Goods and Services/Unpaid Caregiver Training service.

No PPL services added.

**Add**

- **Click Add in Services box** to add services

**Note:** Under Self-Directed Services, the first Add button relates to Companion Services. If this service is added including the dollar amount and then saved, the second Add button relating to Goods and Services will be available to enter additional information.

- Advance to **Step #10: Click the Verification** link under Plan Mod Links

## CM #10 Verification [BACK TO TOC](#) [VERIFICATION INSTRUCTIONS](#)

The verification screen is the final step for the CM to complete.

Enrollment: 7/1/2011 - 6/30/2012 (Active) IBA: \$100,846.00

Print:

### Verification

#### Participant/Guardian Verification

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

#### Relative Disclosure

☐ A provider on the plan is related to the participant.

#### Team Signature and Verification

Please upload a Team Signature Verification form. You can download a copy of the form [here](#).

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### Verification

#### Participant/Guardian Verification

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

- **Read the conflict of interest information in the first tab Participant/Guardian Verification**
- **If it applies, Click the box “This applies to me”**
- **Click View Verification form link**

## CM #10 Verification Form [BACK TO TOC](#) [VERIFICATION INSTRUCTIONS](#)

Participant and Guardian Verification Form		WDH- Behavioral Health Division Developmental Disabilities Section Phone (307) 777-7115 Fax (307) 777-6047
Participant Name: <input type="text"/>	Waiver: <input type="checkbox"/> Adult DD <input type="checkbox"/> Child DD <input type="checkbox"/> ABI	
After discussing these items with the case manager, the Participant or Guardian shall verify the following:		
1. I have participated in the development of this plan and acknowledge my responsibilities as a waiver participant.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. The restrictions in the rights and restoration plan have been explained to me along with my responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. I agree with the rights, restrictions, and restoration plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
4. I have reviewed my choices through a current provider list and have reviewed the waiver services available.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. I know I have a choice between home and community based services and the Wyoming Life Resource Center. I understand I can contact the Division to review possible changes to my providers. For this plan, I have made an informed choice about my providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. I have been informed of my right to a Fair Hearing if I am denied a provider, service, or eligibility to the waiver	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. I agree that providers can administer medications as trained.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Comments (use the above item numbers to describe your comments)		
<input type="text"/>		
Participant/Guardian Signature: _____	Date: ____/____/____	

Page 1 WDH - Behavioral Health Division  
Participant/Guardian Verification Form

Implemented Nov 2011 Rev 10/2012

The Participant and Guardian Verification form above opens, print this out, sign it, scan it and then upload it.

### Verification

#### Participant/Guardian Verification

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

➤ **Click Browse** and upload this document

## CM #10 Verification Signatures [BACK TO TOC](#) [VERIFICATION INSTRUCTIONS](#)

Enrollment: 7/1/2011 - 6/30/2012 (Active) IBA: \$100,846.00  
Print:

### Verification

**Participant/Guardian Verification**

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

**Relative Disclosure**

☐ A provider on the plan is related to the participant.

**Team Signature and Verification**

Please upload a Team Signature Verification form. You can download a copy of the form [here](#).

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- **Check the box if Relative Disclosure applies**
- **Click Browse** and upload the Team Signature & Verification form
- **Click Save**

## CM Finalize IPC [BACK TO TOC](#) [FINALIZE IPC INSTRUCTIONS](#)

Now all the steps in the IPC have been completed, the CM is ready to submit the IPC to the PSS for review and approval.

The screenshot displays the Medicaid Waiver System (MWS) interface. At the top, there is a navigation bar with links for Favorites, MWS - Plan of Care - Workflow, and a user welcome message: "Welcome Benjamin Gray". Below this, the "Medicaid Waiver System" title is prominent, followed by tabs for Task List, Search Cases, Waitlist, Reports, and Admin. The main content area shows details for a specific waiver: "Waiver: DDD - Child", "Participant: McNichols, George", and "Case Manager: Aiken, Kirsten". On the left, a "Waiver Links" sidebar lists various options, with "Plan Status" highlighted under the "Plan of Care Links" section. The main content area displays the "Plan of Care" details, including the plan period (11/9/2011 - 11/8/2012), enrollment date (11/9/2011 - 11/8/2012), and status (Submit Plan Of Care). A "History" section shows the process as "Plan Of Care". Below this, an "Action" section features a dropdown menu set to "Submit to Participant Support Specialist" and a "Complete" button, which is circled in red. A "Links" section at the bottom provides a link to the "Planning Workbook for Individualized Plans of Care". The footer includes the Wyoming Department of Health logo and copyright information: "© 2011 Wyoming Department of Health. All rights reserved."

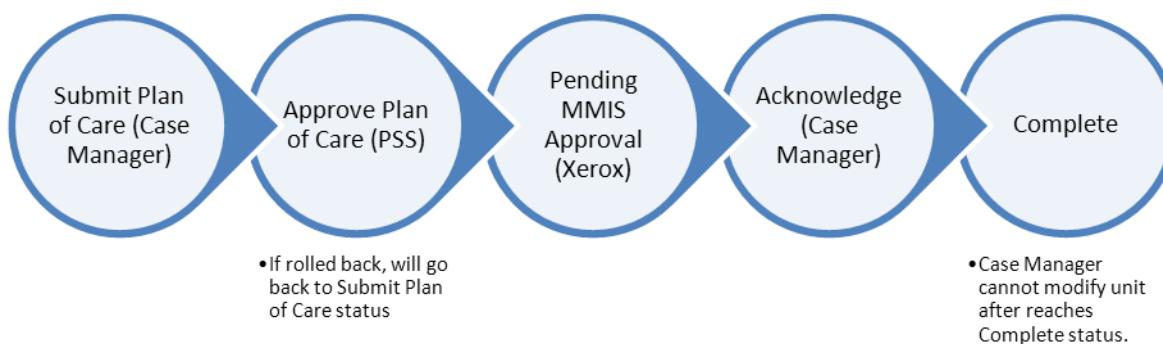
- **Click Plan Status link** under Plan Mod Links
- Under Action, **select “Submit to Participant Support Specialist”**
- **Click Complete**

PSS will review and either Roll back for corrections and clarifications or Approve IPC.

## CM Finalize IPC, cont. [BACK TO TOC](#)

CM can return to the Plan Status link to stay updated on where the IPC is at in the process. The PSS will add comments if there are changes, modifications, or clarifications needed to complete your IPC approval.

### IPC Approval Process



### IPC Approval Process for Traditional Services:

- Refer to diagram above as to the workflow and the User associated with the task
- After the IPC is submitted and the PA's are generated, Case Managers will see on their task list an ACKNOWLEDGEMENT link. This means the plan is completed.
- Case Managers click on the "Acknowledgement" link and it will open the Service Authorization page, and then click "Submit".
- Go back to the "Plan Status" link and it will be noted under status "Complete".
- **NOTE:** Once you see "Approve Plan of Care" under the Description in the History tab, you cannot make any changes. You can make changes when the status says "Submit Plan of Care".

### IPC Approval Process for Self-Directed Services:

Status	Description	Modified By	Modified Date
✓	<a href="#">Submit Plan Of Care</a>		9/18/2012 10:23:58 AM
✓	<a href="#">Approve Plan Of Care</a>	rlatham	9/25/2012 12:19:23 PM
➡	<a href="#">Acknowledge Skip MMIS</a>		

The screen shot above reflects the History under the "Plan Status" link for Self-Directed Services. CM clicks Acknowledge Skip MMIS. The next step is Acknowledge then Complete.

NOTE: A **green** ✓ indicates a task is complete. A **green** ➡ indicates the next pending task to be completed.

## CM Closure Process [BACK TO TOC](#)

When a Participant has moved out-of-state, passed away, quit being on a Waiver, or is no longer eligible, CM must complete the closure screen. After the CM completes the closure information, DFS handles the final closure.

oming Department of Health MWS - Waiver

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plan Enrollments
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Guardian(s)**

Name: Jeff Lowe  
Phone: (307) 630-6192  
Address: 1627 Silver Moon Ct.  
Cheyenne, WY 82009

**Participant Addresses**

Type: Physical/Mailing  
Address: 7411 Elling  
Cheyenne, WY 82009

**Waiver Status**

Waiver: BHD - ADD  
Status: Active (Renewal)  
Start Date: 4/1/2012  
End Date: 3/31/2013  
On Hold: ☐  
**Save**

**All Waivers**

View	Division	Waiver	Case Manager	Agency	Status	Start Date	End Date
	BHD	ADD	Russell, Lucy	RUSSELL, LUCY	Active (Renewal)	4/1/2012	3/31/2013

**Close Case**

Closure:

Notification Date:

Effective Date:

Comment:

**Close**

- **Click Waiver** under Waiver Links
- **Click down arrow next to Closure** in the Close Case tab and select reason for closing case
- **Enter Notification Date** – date process started
- **Enter Effective Date** – date Participant left or passed away or quit a Waiver
- **Enter Comment** – enter a short narrative explaining the reason for the closure and if child is aging out moving to adult waiver, DFS requires the date is noted for this change. Indicate the date in this comment section.
- **Click Close**

## CM Task Allotted Time Line [BACK TO TOC](#)

The following table identifies the task and amount of time allotted for completion. If the time has gone over the allotted time, CM must contact PSS to troubleshoot the problem.

<b>Task</b>	<b>User that Completes</b>	<b>Time Allotted</b>
<b>Submit Plan of Care</b>	Case Manager	Notified 90 days prior then 60 days to complete; otherwise, IPC "late"
<b>Closure Review</b>	Case Manager	7 days on CM task list or bottom task list
<b>Pending PM Review</b>	Program Manager	3 days on PM task list and PSS bottom task list
<b>Pending MMIS Activation</b>	Case Manager	Sitting here more than 7 days, contact DFS
<b>Pending MMIS Approval</b>	MMIS	No more than 3 days on CM task list and bottom task list
<b>Approve Plan of Care</b>	PSS	20 days for Plan renewals  7 days for modifications on PSS top task list
<b>Acknowledge Skip MMIS</b>	Case Manager	Modification that did not require any changes to Pas; task has no set time
<b>Acknowledge</b>	Case Manager	Before IPC or mod start date
<b>Complete LT-104</b>	Case Manager	Notified 90 days prior then 60 days to complete
<b>Submit Psych/Neuro Evaluation</b>	Case Manager	Notified 90 days prior then 60 days to complete
<b>Submit ICAP Evaluation</b>	Case Manager	Notified 90 days prior then 60 days to complete

## CM Task Clean-up; Delete Modifications [BACK TO TOC](#)

### Plan Enrollments

Start Date	End Date	End Reason	Modification Effective Dates
6/1/2012	5/31/2013	Active	<u>TBD (In Progress)</u> , <u>6/1/2012</u>
6/1/2011	5/31/2012	N/A	<u>6/1/2011</u> , <u>11/1/2011</u> , <u>11/17/2011</u>
6/1/2010	5/31/2011	N/A	<u>6/1/2010</u>
6/1/2009	5/31/2010	N/A	<u>6/1/2009</u>
6/1/2008	5/31/2009	N/A	<u>6/1/2008</u>
6/1/2007	5/31/2008	N/A	<u>6/1/2007</u>
6/1/2006	5/31/2007	N/A	<u>6/1/2006</u>

In the example above, a modification was mistakenly started that now needs to be deleted. All modifications must have an effective date; the TBD (In Progress) is an error.

➤ **Click Plan Enrollments** under Waiver Link

➤ **Click on the Modification date to delete**

Note: Modification has not been submitted to MMIS.

The screenshot shows the 'Plan Status' page for a 'Plan Of Care'. On the left is a sidebar with 'Waiver Links' and 'Plan Mod Links'. The main content area shows 'Plan Enrollment Dates: 12/1/2011 - 11/30/2012 (Active)', 'Effective Date: N/A (Modification)', and 'Status: Submit Plan Of Care'. Below this is the 'Plan Mod Details' section with 'Modification Effective Date' and 'Modification Reason: test'. A 'History' table shows one entry: 'Submit Plan Of Care'. At the bottom, there is a 'Delete' button circled in red, and a 'Submit Plan Of Care' button.

➤ This takes CM to Plan Status page, **click Delete button**

## CM Modify Existing IPC [BACK TO TOC](#) [BACK TO INDEX](#)

When a CM needs to modify an existing IPC, complete the following steps:

### Medicaid Waiver System

Task List **Search Cases** Waitlist Reports Admin

**Search Cases**

- [Search](#)
- [Create Case](#)

Wyoming

**Search Cases**

Last Name:  Medicaid ID:

First Name:  Date Of Birth:

SSN:  Gender:

**Search**

### Step 1

- **Click Search Cases tab**
- **Click the box Last Name and enter at least 3 letters of the Participant's last name**
- **Click Search**

### Medicaid Waiver System

Task List **Search Cases** Waitlist Reports Admin

**Search Cases**

- [Search](#)
- [Create Case](#)

Wyoming

**Search Cases**

Last Name:  Medicaid ID:

First Name:  Date Of Birth:

SSN:  Gender:

**Search**

View	Last Name	First Name	Gender	SSN	Medicaid	Waiver Program	Enrolled
	Depp	Johnny	Male	XXX-XX-5734		DDD - ABI	No

Search results rendered Participant that matched search criteria – in this example Johnny Depp.

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

**Search Cases**

- Search  
- Create Case

WYOMING

**Search Cases**

Last Name:  Medicaid ID:

First Name:  Date Of Birth:

SSN:  Gender:

**Search**

View	Last Name	First Name	Gender	SSN	Medicaid	Waiver Program	Enrolled
	Depp	Johnny	Male	XXX-XX-5734		DDD - ABI	No

### Step 2

- **Click icon under the View column** that matches the record searched to open the Participant's IPC

Welcome Waivers Admin

**Medicaid Waiver System**

Task List Search Cases Waitlist Reports Admin

**Enter the reason for accessing this file:**

Reason

Reasons:

- Collecting information for reports
- I am filling in for assigned personnel
- I am supervising my personnel's work
- I have been asked to review this file
- I have been assigned to this case
- Other
- This case has an outstanding task for my role
- Updating financial eligibility

### Step 3

- HIPAA Compliance screen appears if not an Associated User, **click the down arrow in Reason** and select the reason for accessing this file
- **Click Save**

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

The screenshot shows the EMWS interface. On the left is a 'Waiver Links' sidebar with a list of links. 'Plan Enrollments' is circled in red. On the right is the 'Plan Enrollments' table, which displays participant enrollment data.

Start Date	End Date	End Reason	Modification Effective Dates
12/1/2012	11/30/2013	Future	<a href="#">12/1/2012 (In Progress)</a>
12/1/2011	11/30/2012	Active	<a href="#">12/1/2011, 12/22/2011, 1/11/2012, 9/19/2012</a>
12/1/2010	11/30/2011	N/A	<a href="#">12/1/2010, 11/3/2011, 11/22/2011</a>
12/1/2009	11/30/2010	N/A	<a href="#">12/1/2009</a>
12/1/2008	11/30/2009	N/A	<a href="#">12/1/2008</a>
12/1/2007	11/30/2008	N/A	<a href="#">12/1/2007</a>
12/1/2006	11/30/2007	N/A	<a href="#">12/1/2006</a>
12/15/2005	11/30/2006	N/A	<a href="#">12/15/2005</a>

### Step 4

- Under Waiver Links, **click Plans Enrollments**

This screenshot is similar to the previous one but includes a red bracket on the right side of the 'Plan Enrollments' table, pointing to the 'Modification Effective Dates' column. A red-bordered box labeled 'Enrollment History' is placed next to the bracket, indicating that the entire column represents the enrollment history.

Start Date	End Date	End Reason	Modification Effective Dates
11/1/2012	10/31/2013	Future	<a href="#">11/1/2012 (In Progress)</a>
11/1/2011	10/31/2012	Active	<a href="#">11/1/2011, 12/23/2011</a>
11/1/2010	10/31/2011	N/A	<a href="#">11/1/2010</a>
11/1/2009	10/31/2010	N/A	<a href="#">11/1/2009</a>
11/1/2008	10/31/2009	N/A	<a href="#">11/1/2008</a>
11/1/2007	10/31/2008	N/A	<a href="#">11/1/2007</a>
11/1/2006	10/31/2007	N/A	<a href="#">11/1/2006</a>
11/1/2005	10/31/2006	N/A	<a href="#">11/1/2005</a>

**Entire Participant enrollment history is displayed.**

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

### Waiver Links

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plans of Care](#)
- [Individual Budget Amount](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

### Enrollment

Start Date	End Date	End Reason	Plan(s)
8/1/2011	7/31/2012	Active	<u>8/1/2011</u>
8/1/2010	7/31/2011	N/A	<u>8/1/2010</u>
8/1/2009	7/31/2010	N/A	<u>8/1/2009</u>
8/1/2008	7/31/2009	N/A	<u>8/1/2008</u>
8/1/2007	7/31/2008	N/A	<u>8/1/2007</u>
8/1/2006	7/31/2007	N/A	<u>8/1/2006</u>
8/1/2005	7/31/2006	N/A	<u>8/1/2005</u>

### Step 5

- **Click the date seeking to modify** – the most recently approved Plan

### Waiver Links

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plans of Care](#)
- [Individual Budget Amount](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

### Plan of Care Links

- [Plan Status](#)
- [Individual Preferences](#)
- [Demographics](#)
- [Assessments](#)
- [Circle of Supports](#)
- [Needs, Risks, & Restrictions](#)
- [Medical](#)
- [Specialized Equipment](#)
- [Behavioral Supports](#)
- [Service Authorization](#)
- [Verification](#)

**Plan:** 8/1/2011 - 7/31/2012 (Renewal) **Status:** Closed  
**Enrollment:** 8/1/2011 - 7/31/2012 (Active) **IBA:** \$75,244.00  
**Print:**

### History

Process: Plan Of Care

Status	Description	Modified By	Modified Date
	Closed		

### Action

Rollback

### Links

This plan has been approved and Plan Dates/Services can no longer be modified. If you would like to modify services for this participant, click the Modify button to start a new process to create a new instance of the Plan of Care. All existing data will be copied to the new plan.

**Modify**

[Planning Workbook for Individualized Plans of Care](#)

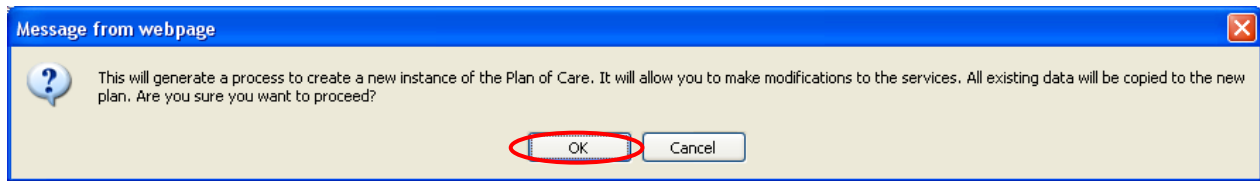
### Step 6

- **Click the Modify button**
- **Document reason for modification**
- **Click Modify**

This will generate a process to create a new instance of the Plan of Care. It will allow you to make modifications to the services. All existing data will be copied to the new plan. Are you sure you want to proceed?

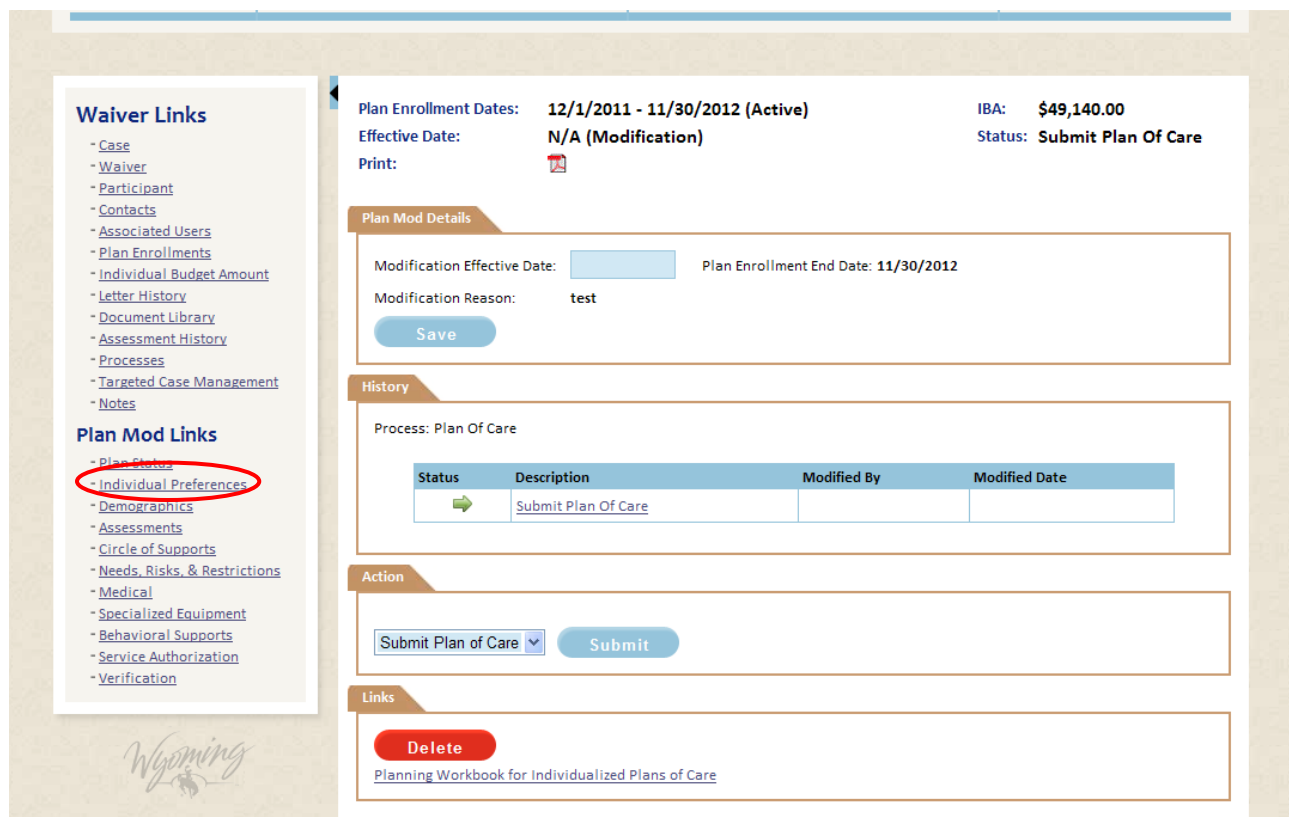
**Modification Reason**

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)



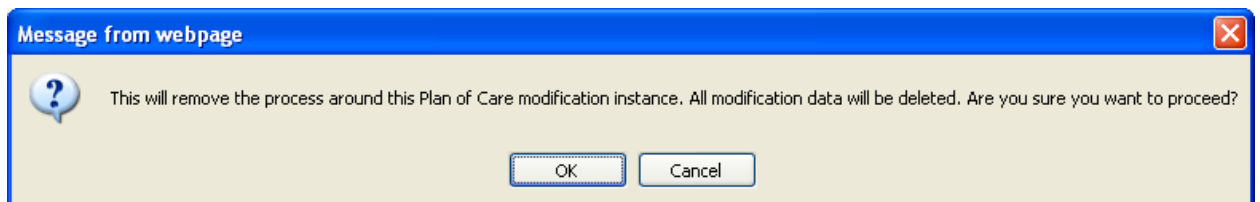
### Step 7

- Message alerts CM creating a new instance of Plan of Care. This means all existing data from Plan of Care will be copied to a new Plan of Care. This also means CM is creating a new Modification – thus if this is what CM intended to do, **Click OK** if not Click Cancel.

A screenshot of a web application interface. On the left is a sidebar with two sections: "Waiver Links" and "Plan Mod Links". The "Plan Mod Links" section has a red circle around the "Individual Preferences" link. The main content area is titled "Plan Enrollment Dates: 12/1/2011 - 11/30/2012 (Active)" and "IBA: \$49,140.00". Below this, there's a "Plan Mod Details" section with fields for "Modification Effective Date", "Modification Reason: test", and "Plan Enrollment End Date: 11/30/2012". There's a "Save" button. Below that is a "History" section with a table showing a single entry: "Submit Plan Of Care" with a green arrow icon. At the bottom is an "Action" section with a dropdown menu set to "Submit Plan of Care" and a "Submit" button. There's also a "Delete" button and a link to "Planning Workbook for Individualized Plans of Care".

### Step 8

- **Click Individual Preferences** link under Plan Mod Links
- NOTE: Click Delete** - message box below appears



## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

**Waiver Links**

- Case
- Waiver
- Participant
- Contacts
- Associated Users
- Plans of Care
- Individual Budget Amount
- Letter History
- Document Library
- Assessment History
- Processes
- Targeted Case Management
- Notes

**Plan of Care Links**

- Plan Status
- Individual Preferences
- Demographics
- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- **Service Authorization**
- Verification

**Plan:** 8/1/2011 - 7/31/2012 (Modification) **Status:** Submit Plan Of Care  
**Enrollment:** 8/1/2011 - 7/31/2012 (Active) **IBA:** \$75,244.00  
**Print:**

**Individual Preferences**

**Modification Effective Date:** 8/1/2011 - 7/31/2012 (Modification) **Plan End Date:** 7/31/2012

**Annual Team Planning Meeting:**  **November, 2011**

Su	Mo	Tu	We	Th	Fr	Sa
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	1	2	3
4	5	6	7	8	9	10

Today: November 4, 2011

**Participant's Desired Accomplishments for the U**

**Participant's Personal Preferences:**

**Important Things To Know About Participant:**

**Save**

### Step 9

- **Enter the Modification Effective Date** (click box and calendar appears, click date)
- **Click Save**

### Step 10

- **Click Services Authorization** under Plan Mod Links.  
Now CM is ready to **modify an existing Service OR add a new service.**

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

Amount Remaining: \$2.54

Services

Note: Hover over the Service Code to view the full service name. Hover over the icon in the goal column to view the entire Goal.

Print Service Report:

Service	Provider	Unit Cost	Units	Cost	Start Date	End Date	Goal	PA	Units Used	Last Payment
T2002	MAGIC CITY ENTERPRISES, INC.	\$18.19	180	\$3,274.20	8/1/2011	7/31/2012		1213902004		
T2016U8	MAGIC CITY ENTERPRISES, INC.	\$120.52	365	\$43,989.80	8/1/2011	7/31/2012		1213902004		
T2019UQ	MAGIC CITY ENTERPRISES, INC.	\$2.73	4650	\$12,694.50	8/1/2011	7/31/2012		1214902006		
T2021	MAGIC CITY ENTERPRISES, INC.	\$3.00	4008	\$12,024.00	8/1/2011	7/31/2012		1213902004		
T2022	DODSON, HEATHER	\$271.58	12	\$3,258.96	8/1/2011	7/31/2012		1213902005		

Add

Self-Directed Services

No services added.

Add

### Step 11

- From the list of Services screen **click the icon on the left to edit the existing service CM is seeking to modify**
- Under Units Used you will see how many units have been used. Units cannot go lower than Units Used.

**Modal Screen**

T1005 - Respite Care

Service: T1005 - Respite Care

Provider: NORTHERN D.D.S.P. INC.

Unit Cost: \$3.53

Units Allocated: 4178

Total Cost: \$14,748.34

Goal for this Service:

PA Number: 1207902045 - 02

Start Date: 7/1/2011

End Date: 6/30/2012

I acknowledge that:

☐ Not during school

☐ Not when Caregiver is working

☐ Schedule meets documentation requirements listed

Save Cancel

Goods and Services/Unpaid Caregiver Training

Before adding a Goods and Services/Unpaid Caregiver Training service, you must add at least one Fiscal Employer Agent - PPL service in the above section.

No PPL services added.

**Modal Screen** appears showing the current service details – Service, Provider, Units, Cost, Goal, etc.

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

**T1002 - Skilled Nursing**

Service	T1002 - Skilled Nursing
Provider	MAGIC CITY ENTERPRISES, INC.
Unit Cost	\$18.19
Units Allocated	180
Total Cost	\$3,274.20
Goal for this Service	
PA Number	1213902004 - 01
Start Date	8/1/2011
End Date	7/31/2012
Upload File	<input type="text"/> Browse... Upload
No documents uploaded for this service.	
Save Cancel	

### **Step 12**

- CM can change Units Allocated – **click in box and enter number** (system automatically enters unit cost)
- **Enter the goal** for the service (refer to Instructions for details)

**IMPORTANT: Start date must be the same as the modification effective date**

- **Click Upload** to upload the supporting documents required for the following services:
  - Day & Res Hab – changes in Supervision Level and Intervention Request only
  - Environmental Mods
  - Occupational Therapy, Speech Therapy, Physical Therapy
  - Skilled Nursing
  - Specialized Equipment
  - Individually Directed Goods and Services
  - Unpaid Caregiver Training
- **Click Save** after changes have been made

## CM Modify Existing IPC, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

**T1005 - Respite Care**

Service: T1005 - Respite Care

Provider: NORTHERN D.D.S.P. INC.

Unit Cost: \$3.53

Units Allocated: 4178

Total Cost: \$14,748.34

Goal for this Service: [Edit]

PA Number: 1207902045 - 02

Start Date: 7/1/2011

End Date: 6/30/2012

I acknowledge that:

- ☒ Not during school
- ☐ Not when Caregiver is working
- ☐ Schedule meets documentation requirements listed

**Save** **Cancel**

**Goods and Services/Unpaid Caregiver Training**

Before adding a Goods and Services/Unpaid Caregiver Training service, you must add at least one Fiscal Employer Agent - PPL service in the above section.

No PPL services added.

### **Step 13**

Some services will not have the Upload file field but will have the “I acknowledge” check boxes.

- **Click the boxes next to the “I acknowledge” questions that apply**
- **Click Save**




**IMPORTANT NOTE:** System DOES NOT allow USERS to back date.

## CM Modify Existing IPC, add Service [BACK TO TOC](#) [BACK TO INDEX](#)

CM completes Steps 1 – 11 noted prior then click Add to add a new service.


- [Circle of Supports](#)
- [Needs, Risks, & Restrictions](#)
- [Medical](#)
- [Specialized Equipment](#)
- [Behavioral Supports](#)
- [Service Authorization](#)
- [Verification](#)













Amount Remaining: \$2.54

**Services**

Note: Hover over the Service Code to view the full service name. Hover over the icon in the goal column to view the entire Goal.

Print Service Report: 

Service	Provider	Unit Cost	Units	Cost	Start Date	End Date	Goal	PA	Units Used	Last Payment
 T1002	MAGIC CITY ENTERPRISES, INC.	\$18.19	180	\$3,274.20	8/1/2011	7/31/2012		1213902004		
 T2016U8	MAGIC CITY ENTERPRISES, INC.	\$120.52	365	\$43,989.80	8/1/2011	7/31/2012		1213902004		
 T2019UQ	MAGIC CITY ENTERPRISES, INC.	\$2.73	4650	\$12,694.50	8/1/2011	7/31/2012		1214902006		
 T2021	MAGIC CITY ENTERPRISES, INC.	\$3.00	4008	\$12,024.00	8/1/2011	7/31/2012		1213902004		
 T2022	DODSON, HEATHER	\$271.58	12	\$3,258.96	8/1/2011	7/31/2012		1213902005		

**Add**

**Self-Directed Services**

No services added.

**Add**

➤ **Click Add** in Services box

## CM Modify Existing IPC, add Service, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

The screenshot shows a 'New Service' modal window. The title 'New Service' is circled in red. The modal contains the following fields:

- Service: (dropdown menu)
- Unit Cost: (text input)
- Units Allocated: (text input)
- Total Cost: (text input)
- Goal for this Service: (text input)
- Start Date: 7/1/2011
- End Date: 6/30/2012

At the bottom of the modal are 'Save' and 'Cancel' buttons. Below the modal, there is a section for adding PPL services with a message 'No PPL services added.' and an 'Add' button.

Modal screen “New Service” appears.

The screenshot shows a modal window titled 'S5165NU - Environmental Modification (New)'. The modal contains the following fields:

- Service: S5165NU - Environmental Modification (New)
- Provider: RENEW
- Unit Cost: 1
- Units Allocated: 3000
- Total Cost: \$3,000.00
- Goal for this Service: Increased independence in bathroom
- Start Date: 11/7/2011
- End Date: 6/30/2012

At the bottom of the modal are 'Save' and 'Cancel' buttons. The background shows a 'Plan of Care Links' sidebar and a table with columns for Service, Units, and Cost.

- Click the drop down arrows, **click selection for Service and Provider**
- **Complete remaining fields** and refer to page 34 for a list of Services that require supporting documents are uploaded
- **Click Save**

**IMPORTANT:** Start date must be the same as or later than the modification effective date.

## CM Modify Existing IPC, add Service, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

State of Wyoming - Calendar MWS - PoC - Services Av... X New Tab

- Assessments
- Circle of Supports
- Needs, Risks, & Restrictions
- Medical
- Specialized Equipment
- Behavioral Supports
- Service Authorization
- Verification

Amount Remaining: (\$2,982.26)

### Services

Note: Hover over the Service Code to view the full service name. Hover over the icon in the goal column to view the entire Goal.

Print Service Report:

Service	Provider	Unit Cost	Units	Cost	Start Date	End Date	Goal	PA	Units Used	Last Payme
S5135	NORTHERN D.D.S.P. INC.	\$3.89	840	\$3,267.60	7/1/2011	6/30/2012		1207902045		
S5165NU	RENEW	\$1.00	3000	\$3,000.00	11/7/2011	6/30/2012	<b>X</b>			
T1005	NORTHERN D.D.S.P. INC.	\$3.53	4178	\$14,748.34	7/1/2011	6/30/2012		1207902045		
T2020U3	NORTHERN D.D.S.P. INC.	\$73.01	236	\$17,230.36	7/1/2011	6/30/2012		1207902045		
T2022	SPENCE CASE MANAGEMENT, DEB SPENCE	\$271.58	12	\$3,258.96	7/1/2011	6/30/2012		1207902046		

Add

### Self-Directed Services

No services added.

Add

After a new service has been added, there will be a red **X** next to the record as noted above.

This is how CM can identify a new service has been added.

## CM Modify Existing IPC, Verification [BACK TO TOC](#) [BACK TO INDEX](#)

The next step to editing a modification or entering a new service is the Verification.

Enrollment: 7/1/2011 - 6/30/2012 (Active) IBA: \$100,846.00  
Print:

**Verification**

**Participant/Guardian Verification**

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

**Relative Disclosure**

☐ A provider on the plan is related to the participant.

**Team Signature and Verification**

Please upload a Team Signature Verification form. You can download a copy of the form [here](#).

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- **Click Verification** under Plan Mod Links

**Verification**

**Participant/Guardian Verification**

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

Read the conflict of interest information in the first tab Participant/Guardian Verification

- **If it applies, Click the box “This applies to me”**
- **Click View Verification form link**

## CM Modify Existing IPC, Verification, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

Participant and Guardian Verification Form		WDH- Behavioral Health Division Developmental Disabilities Section Phone (307) 777-7115 Fax (307) 777-6047	
Participant Name:	<input type="text"/>	Waiver:	<input type="checkbox"/> Adult DD <input type="checkbox"/> Child DD <input type="checkbox"/> ABI
After discussing these items with the case manager, the Participant or Guardian shall verify the following:			
1. I have participated in the development of this plan and acknowledge my responsibilities as a waiver participant.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. The restrictions in the rights and restoration plan have been explained to me along with my responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. I agree with the rights, restrictions, and restoration plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
4. I have reviewed my choices through a current provider list and have reviewed the waiver services available.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. I know I have a choice between home and community based services and the Wyoming Life Resource Center. I understand I can contact the Division to review possible changes to my providers. For this plan, I have made an informed choice about my providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. I have been informed of my right to a Fair Hearing if I am denied a provider, service, or eligibility to the waiver	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. I agree that providers can administer medications as trained.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Comments (use the above item numbers to describe your comments)			
<input type="text"/>			
Participant/Guardian Signature:	<input type="text"/>	Date:	<input type="text"/>

Page 1 WDH - Behavioral Health Division  
Participant/Guardian Verification Form

Implemented Nov 2011 Rev 10/2012

The document above opens, print out, sign, scan then upload.

### Verification

#### Participant/Guardian Verification

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

➤ **Click Browse and upload the document**

## CM Modify Existing IPC, Verification, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

Enrollment: 7/1/2011 - 6/30/2012 (Active) IBA: \$100,846.00

Print:

### Verification

#### Participant/Guardian Verification

A conflict of interest is a situation in which the case manager has competing or conflicting interests or loyalties because s/he or his/her organization provides other services or supports to the participant. The participant/legally authorized representative shall be informed that s/he can choose a case manager not affiliated with any other services received. If a case manager is providing other services on a plan, or the organization the case manager works for provides other services, it is a conflict of interest.

This applies to me: ☐

[View Verification Form](#)

Please upload the Participant/Guardian Verification form.

[Browse...](#)

#### Relative Disclosure

☒ A provider on the plan is related to the participant.

#### Team Signature and Verification

Please upload a Team Signature Verification form. You can download a copy of the form [here](#).

[Browse...](#)

[Save](#)

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- **Check the box if Relative Disclosure applies**
- **Click Browse and upload the Team Signature form**
- **Click Save**

## CM Modify Existing IPC, Submit [BACK TO TOC](#) [BACK TO INDEX](#)

**Waiver Links**

- [Case](#)
- [Waiver](#)
- [Participant](#)
- [Contacts](#)
- [Associated Users](#)
- [Plan Enrollments](#)
- [Individual Budget Amount](#)
- [Letter History](#)
- [Document Library](#)
- [Assessment History](#)
- [Processes](#)
- [Targeted Case Management](#)
- [Notes](#)

**Plan Mod Links**

- [Plan Status](#)
- [Individual Preferences](#)
- [Demographics](#)
- [Assessments](#)
- [Circle of Supports](#)
- [Needs, Risks, & Restrictions](#)
- [Medical](#)
- [Specialized Equipment](#)
- [Behavioral Supports](#)
- [Service Authorization](#)
- [Verification](#)

**Plan Enrollment Dates:** 12/1/2012 - 11/30/2013 (Future) **IBA:** \$33,052.00  
**Effective Date:** 12/1/2012 (Renewal) **Status:** Submit Plan Of Care  
**Print:**

**Plan Mod Details**

Plan Enrollment Start Date: 12/1/2012 Plan Enrollment End Date: 11/30/2013  
The start date can no longer be changed for this plan, or you do not have permission to change the start date.

**History**

Process: Plan Of Care

Status	Description	Modified By	Modified Date
	Submit Plan Of Care		

**Action**

Submit Plan of Care **Submit**

**Links**


[Planning Workbook for Individualized Plans of Care](#)

- **Click Plan Status** under Plan Mod Links
- **Click down arrow under Action, select Submit Plan of Care**
- **Click Submit**

PSS will review and either Roll back noting corrections or Approve Plan of Care.

## CM Submit Quarterly Review [BACK TO TOC](#) [BACK TO INDEX](#)

The first day of the month the quarterly review is due (i.e. Oct, 1 or Jan 1, or Apr 1, or July 1) a task will show up on the CM task list. Under Status it will show Pending Quarterly Review.



### Medicaid Waiver System

Task List
Search Cases
Waitlist
Reports
Admin

#### Task List

Hide Filter
Contacts

Last Name:

Division: BHD

Process: Quarterly Review

Effective Date:

Filter By Role:

Medicaid ID:

Waiver Type:

Status: Pending Quarterly Review

SSN:

County:

Filter

Open processes for all cases that do not require your direct action.

View	Last Name	First Name	SSN	Medicaid Number	Waiver	Process	Status	Effective Date	Assigned	Days
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1
					BHD - ABI	Quarterly Review	Pending Quarterly Review		No	1

1 2 3 4 5 6 7 8 9 10 ...

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➤ **Click icon under View** next to the Participant requiring Quarterly Review

## CM Submit Quarterly Review, cont. [BACK TO TOC](#) [BACK TO INDEX](#)

Case Management Quarterly Review

Community Involvement Satisfaction: Neutral

List the approximate number of each type of community activity from this past quarter:

○ Leisure Activities:

○ Church/Cultural Events:

○ Errands:

1 to 3 this past quarter

1 to 3 this past quarter

1 to 3 this past quarter

Satisfaction that Services Support Desired Accomplishments: Neutral

☐ Check box if participant completed a training objective in this reporting period.

☐ Check box if participant has a Positive Behavior Support Plan.

**Restraint & Restriction Data Reporting**

3 Months Month/Year	# of Restraints			Possessions	Privacy	# of Restrictions Communication	Community Access	
	Mechanical	Physical	Chemical					
07/2012	0	0	0	0	0	0	0	<a href="#">Edit</a>
08/2012	0	0	0	0	0	0	0	<a href="#">Edit</a>
09/2012	0	0	0	0	0	0	0	<a href="#">Edit</a>

School Attendance: Does not attend school

☐ Is Participant Employed?

Unemployment Reason: Too young

Other Comments:

Save

Action: Completed Quarterly Review
Submit

- **Click the drop down menus and select data**
- **Click Edit to update Restraint & Restriction Data Reporting**
- **Click Save** after all the information has been completed
- **Click Submit under Action** – this action button will disappear letting CM know it has been submitted. CM can also verify by clicking Processes under Waiver Links and it will show “Completed Quarterly Review” under Current Status.

## File Naming Conventions for Uploaded Documents

### NAMING CONVENTION Policy and Procedures

#### Policy

All users of the Electronic Medicaid Waiver System (EMWS) shall use the Division's standardized naming convention for saving documents to a person's file on the Electronic Medicaid Waiver System.

#### Procedures

Files will be named in the following manner:

1. WAIVER INITIALS: **ADD, CDD, ABI**
2. PARTICIPANT: **LAST NAME. FIRSTNAME**
3. DOC TITLE ABBREVIATED: (**see list below**)
4. DATE: **YYYY.MM.DD**

**Example:** CDD.Staunton.Jamie.Appl.2011.10.28 (separate with a period)

1                      2                      3                      4

#### Document Title Abbreviations:

**Appl** - Application

**CMSel** -Case Manager Selection

**Psych** - Psychological Evaluation

**Neuro** - Neuropsychological Evaluation

**Guard** - Guardianship Papers

**LT104** - LT-104 Level of Care Assessment

**ICAPlist** - ICAP Checklist

**ICAP** - ICAP 3 page summary form

**PBSP**- Positive Behavior Support Plan

**MAR** - Medication Assistance Record

**Seiz** - Seizure Protocol

**Vagus** - Vagus Nerve Stimulator Protocol

**Meal** - Mealtime Protocol

**Posit** - Position Protocol

**ROI** - Release of Information

**TeamSign** - Team Signature Verification Form

**Conflict** - Conflict of Interest Form

**Relative** - Relative Disclosure Form

**IBAAdjust** - IBA Adjustment Request

**Goods** - Goods and Services Form

**Unpaid** - Unpaid Caregiver Service Form

**\*Service Name\*** - Service Form for a specific service.

**SkNurseOrd** - Physician's order for Skilled Nursing

**RestraintOrd** - Order for Restraint